

Thalassemia Questionnaire

CLIENT NAME: _____		Date: _____	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of birth: _____	Height: _____' _____" Weight: _____
Tobacco Use: <input type="checkbox"/> Never used <input type="checkbox"/> Totally stopped		Date stopped: _____	<input type="checkbox"/> Use now Type of nicotine product: _____
Type of Coverage: <input type="checkbox"/> Term <input type="checkbox"/> UL <input type="checkbox"/> Survivor <input type="checkbox"/> Disability		Coverage Amount: _____	
Annual Income: _____		Occupation/Job duties: _____	State of Residence: _____
Anticipated Premium: _____			
FAMILY HISTORY			
Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide? <i>If yes, use separate sheet to provide this information, including age of onset and date of death</i>			
PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

Type of Thalassemia (specify if trait, minor, intermedia, major): _____

Age at Diagnosis: _____

Symptoms (Fatigue, Pallor, Jaundice, Growth Delays): _____

History of Anemia Severity: _____

Any history of Splenomegaly/Hepatomegaly: _____

Hemoglobin Electrophoresis Results: _____

CBC Results (hemoglobin/hematocrit/platelets): _____

Results of Iron Studies: _____

Ferritin Level: _____

Blood Transfusion History: _____

Treatment(s)/Date of last: _____

Associated Complications: _____

Infections (Post-Splenectomy): _____