

**MEDICAL HISTORY QUESTIONNAIRE: CERVICAL CANCER**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Tobacco Usage:

Coverage Information:

Never  
 Former Date Stopped: \_\_\_\_\_  
 Current Type: \_\_\_\_\_

Type:  Term  UL  IUL  
 WL  VUL  Survivorship  
 Face Amount: \_\_\_\_\_  
 Premium Tolerance: \_\_\_\_\_

**Proposed Insured's Existing Insurance**

Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis \_\_\_\_\_

2. What stage was the cancer?

0  IA  IB  IIA  IIB  
 III  IV

3. How was the cancer treated? (check all that apply)

Cone surgery  Total Hysterectomy  Radiation Therapy  
 Chemotherapy

4. Date treatment was completed: \_\_\_\_\_

5. Has there been any evidence of recurrence?  No  Yes

If yes, please provide details: \_\_\_\_\_

6. Please list current medications

Name of Medication	Dosage	Reason

7. Are there any other health issues? (Additional Questionnaires may be required)  No  Yes

If yes, please provide details: \_\_\_\_\_