



Thrombocytopenia Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/F

Tobacco Usage: _____ Face Amount: _____

____ Term 10 15 20 30 ____ UL

1. When was the proposed insured diagnosed with Thrombocytopenia? _____

2. What type of Thrombocytopenia has been diagnosed?

- Immune Thrombocytopenia purpura
- Drug-induced immune Thrombocytopenia
- Drug-induced nonimmune Thrombocytopenia
- Thombotic Thrombocytopenia purpura
- Primary Thrombocytopenia
- Disseminated intravascular coagulation
- Hypersplenism

3. Does the proposed insured experience any of the following symptoms currently or in the past?
(Check all that apply)

- Bruising
- Nosebleeds
- Rash
- Hemorrhage
- GI bleeding
- Bleeding in the brain

4. How is, the proposed insured, being treated? _____

5. Is the proposed insured currently taking any medication for this condition, or any other?
____ Yes ____ No (If yes, please provide name, dosage, and frequency):

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____