Polycythemia Questionnaire

Name: ______________________________ Date of Birth: _______________________

Height: ___________ Weight: ____________ Sex: M/F

Tobacco Usage: _______________________ Face Amount: _____________________

State of Residence: _________________________

___Term 10 15 20 30 ___UL

1. When was the proposed insured diagnosed with Polycythemia? ____________________________

2. Does the proposed insured suffer from any of the following symptoms? (Check all that apply)

___Headache ___Dizziness ___Itchiness ___Phlebitis
___Vision abnormalities ___Skin discoloration ___Fatigue
___Shortness of breath

3. Has the proposed insured ever been treated for this condition with any of the following:

___Phlebotomy Details: ____
___Chemotherapy Details: ____
___Medication Details: ____

4. Has the proposed insured ever experienced any of the following?

___Thrombosis Date: _____________________________
___Peptic Ulcer Disease Date: _____________________________
___Leukemia: Date: _____________________________
___Gout Date: _____________________________
___Heart Failure Date: _____________________________
___Myelobibrosis Date: _____________________________

5. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide the name, dosage, and frequency of all medications):

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