



## Primary Biliary Cirrhosis 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? \_\_\_\_\_

2. Does the proposed insured experience any of the following symptoms (check all that apply)

\_\_\_ Fatigue \_\_\_ Itchy Skin \_\_\_ Jaundice \_\_\_ Xanthelasmata  
\_\_\_ Esophageal varices \_\_\_ Fluid retention in abdomen \_\_\_ Esophageal varices  
\_\_\_ Hepatic encephalopathy

3. What Stage has been diagnosed?

\_\_\_ Stage 1 – Portal Stage \_\_\_ Stage 2 – Periportal Stage  
\_\_\_ Stage 3 – Septal Stage \_\_\_ Stage 4 – Biliary Cirrhosis

4. When did the proposed insured last have blood testing? \_\_\_\_\_

(Please provide the results of the following):

Alkaline Phosphatase \_\_\_\_\_

AST \_\_\_\_\_

ALT \_\_\_\_\_

5. Has the proposed insured had any of the following:

\_\_\_ Ultrasound Date: \_\_\_\_\_ Results: \_\_\_\_\_

\_\_\_ CT Scan Date: \_\_\_\_\_ Results: \_\_\_\_\_

\_\_\_ Liver Biopsy Date: \_\_\_\_\_ Results: \_\_\_\_\_

\_\_\_ ERCP Date: \_\_\_\_\_ Results: \_\_\_\_\_

6. Has the proposed insured received any of the following treatments for this condition?

(Check all that apply)

\_\_\_ Ursodiol Dates: \_\_\_\_\_

\_\_\_ Cholestyramine Dates: \_\_\_\_\_

7. Does the proposed insured drink alcohol? \_\_\_ Yes \_\_\_ No

(If yes, how much and how frequently): \_\_\_\_\_

8. Is the proposed insured 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: \_\_\_\_\_