Von Willebrand's Disease 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. What classification of Von Willebrand's Disease has been diagnosed?
___Type 1 ___Type 2 ___Type 3

3. Does the proposed insured experience any of the following symptoms: (Check all that apply)
___Frequent bloody noses ___Bleeding from the gums ___Blood in urine ___Bruising easily
___Black, tarry or blood stools ___Bleeding into joints ___Heavy menstrual periods

4. Is the proposed insured currently receiving, or has received in the past, any of the following treatments?
___Desmopressin medication ___Clotting factor replacement therapies ___Antifibrinolytic Agents
___Hormone Therapy ___Topical Medication

Details:
____
____
____

5. Does the proposed insured know the results of the following tests? ___Yes ___No
___Prothrombin Time ___Partial Thromboplastin time
Details:____
____

6. Is the proposed insured taking any medication related to this condition or any other?
___Yes ___No

(If yes, please provide the name, dosage and frequency):
____
____
____

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