Von Willebrand's Disease Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured first diagnosed with Von Willebrand's Disease? _____

2. What classification of Von Willebrand's Disease was diagnosed?

   ___ Type 1 ___ Type 2 ___ Type 3

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

   ___ Frequent bloody nose
   ___ Blood in the urine
   ___ Black, tarry or blood stools
   ___ In women, heavy menstrual periods
   ___ Bleeding from the gums
   ___ Bruising easily
   ___ Bleeding into joints
   ___ Other: _____

4. Has the proposed insured received any of the following treatments?

   ___ Desmopressin medication Details: _____
   ___ Clotting factor replacement therapies Details: _____
   ___ Antifibrinolytic agents Details: _____
   ___ Hormone therapy Details: _____
   ___ Topical medication Details: _____
   ___ Other: _____

5. Does the proposed insured know the results of the following tests?

   ___ Prothrombin Time Details: _____
   ___ Partial thromboplastin time Details: _____

6. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s) _____
   _____
   _____

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