

CANCER QUESTIONNAIRE

Name: _____ Date of Birth: _____

Height _____ Weight _____ Cigarette Smoker: ☐ Yes ☐ No Quantity per day: _____

1. Type of cancer:

- ☐ Bladder
- ☐ Breast
- ☐ Cervical
- ☐ Colon or rectal
- ☐ Melanoma
- ☐ Prostate
- ☐ Skin
- ☐ Other _____

2. Date diagnosed (month & year) _____

3. Stage of cancer:

- ☐ 1 ☐ 2 ☐ 2a ☐ 2b ☐ 2c ☐ 3 ☐ 3a ☐ 3b ☐ 4

4. Please check all treatment(s) received and date completed (month & year):

- ☐ Surgery _____
- ☐ Chemotherapy _____
- ☐ Radiation _____
- ☐ Hormone _____
- ☐ Other (please specify) _____

5. Has there been any evidence of recurring cancer? ☐ Yes ☐ No

If yes, month & year _____ Location _____

6. Please list all medication currently being taken: _____

7. If colon or rectal cancer: Dukes scale ☐ A ☐ B1 ☐ B2-3 ☐ C1 ☐ C2 ☐ D

8. If melanoma: Clarks level ☐ I ☐ II ☐ III ☐ IV ☐ V

Location of melanoma and depth: _____

9. If prostate cancer, what was most recent PSA test result? _____

Gleason's Grade ☐ 2-5 ☐ 6 ☐ 7 ☐ 8-10

Name of physician with cancer records and date last seen: _____

Address: _____

Notes/comments: _____

Signature of Proposed Insured: _____ Date: _____

Witnessed by: _____