

# Thalassemia Questionnaire

Agent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male / Female \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ State: \_\_\_\_\_ Smoker: Y / N \_\_\_\_\_ Face Amount: \_\_\_\_\_  
Type of Insurance: Universal Life Whole Life Survivorship Term (# of years \_\_\_\_\_)

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1. When was the proposed insured diagnosed with Thalassemia? \_\_\_\_\_

2. What type of Thalassemia was diagnosed?

Thalassemia Major Thalassemia Intermedia Thalassemia Minor

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

<u>Anemia</u>	<u>Pallor</u>	<u>Fatigue</u>
<u>Weakness</u>	<u>Blood in urine</u>	<u>Shortness of breath</u>
<u>Jaundice</u>	<u>Enlarged spleen</u>	<u>Enlarged liver</u>
<u>Skull deformity</u>	<u>Mongoloid faces</u>	<u>Heart enlargement</u>

4. How is the proposed insured being treated? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Have the following tests been completed for the proposed insured?

<u>Hepatitis Panel (A,B,C)</u>	<u>Normal: Date: _____</u>	<u>Abnormal: Date: _____</u>
<u>Liver Ultrasound/CT/MRI</u>	<u>Normal: Date: _____</u>	<u>Abnormal: Date: _____</u>
<u>Liver Biopsy</u>	<u>Normal: Date: _____</u>	<u>Abnormal: Date: _____</u>

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

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