



Thyroid Cancer Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:					
DOB:	Gender	Height	Weight	Marital Status	
Occupation & Length of Employment:					
Tobacco Use	Never Used	Totally Stopped		Current User	
		Date Stopped		Type Used	
Type of Coverage	Term	UL	Survivor	Amount \$	

Essential Information

1	Date of Diagnosis	Date last treatment was completed			
2	Please check the type(s)	Papillary or Papillary/follicular		Anaplastic	
		Follicular		Hurthle	
		medullary			
3.	What was the stage of the tumor?				
4.	Check the type of treatments that have been administered	Surgery		Chemotherapy	
		1 st Treatment		External Radiation Treatment	
<i>If surgery was done, please explain</i>					
3	List current medications (provide accurate name, dosage and reason)				
5.	Is there a history of metastatic disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide details		
7.	List any other Health issues (another questionnaire may be needed)				