

Thyroid Disease 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 first Diagnosis				
2	Was the thyroid disease diagnosed as : (more than one is possible)	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	
		Goiter		Hyperthyroidism	
		<input type="checkbox"/> No		<input type="checkbox"/> No	
		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	
Thyroid Nodule		Hypothyroidism			
<input type="checkbox"/> No		<input type="checkbox"/> No			
3	How is the thyroid disease being treated?	<input type="checkbox"/> Surgery		<input type="checkbox"/> Radioactive iodine	
		<input type="checkbox"/> Medication			
		<i>Give details:</i>			
4	Has a biopsy or fine needle aspiration (FNA) been done?	<input type="checkbox"/> Yes	If yes, provide a copy of the report		
		<input type="checkbox"/> No			
5	List current medications (accurate name, dosage and reason)				
6	Does the client have any other health issues	<input type="checkbox"/> Yes	If yes provide details:		
		<input type="checkbox"/> No			