



Polycythemia Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/F

Tobacco Usage: _____

Face Amount: _____

State of Residence: _____

___Term 10 15 20 30 ___UL

1. When was the proposed insured diagnosed with Polycythemia? _____

2. Does the proposed insured suffer from any of the following symptoms? (Check all that apply)

___Headache ___Dizziness ___Itchiness ___Phlebitis
___Vision abnormalities ___Skin discoloration ___Fatigue
___Shortness of breath

3. Has the proposed insured ever been treated for this condition with any of the following:

___Phlebotomy Details: _____
___Chemotherapy Details: _____
___Medication Details: _____

4. Has the proposed insured ever experienced any of the following?

___Thrombosis Date: _____
___Peptic Ulcer Disease Date: _____
___Leukemia: Date: _____
___Gout Date: _____
___Heart Failure Date: _____
___Myelobibrosis Date: _____

5. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide the name, dosage, and frequency of all medications):

