Sikle Cell Anemia

Name_____ Date of Birth: _____

Height: _____ Weight_____ Sex: M/F

Tobacco usage: _____ Face Amount: _____

___Term 10 15 20 30 ___UL

1. When was Sikle Cell Anemia diagnosed? _____

2. What type of sickle cell anemia does your client have?
___ Sickle cell (SS) ___ Sickle cell (SC) ___ Sickle cell trait (SA) ___ Hemoglobin C

3. Is there a history of complications? ___Yes ___No
(If yes, check those that apply and give the date of the last episode)

___ Painful crisis	Date: _____
___ Aseptic recrasis of bones	Date: _____
___ Leg ulcers	Date: _____
___ Lung scarring	Date: _____
___ Thrombosis	Date: _____
___ Enlarged heart	Date: _____

___ Other (Please describe) _____

4. What is the current hemoglobin?_____

5. Are there other medical conditions? ___Yes ___No
If yes, please list: _____
_____

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

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