



# Thyroid Cancer Questionnaire

Name

DOB

Gender

Desired face amount and type of coverage:	
Height and Weight:	
Date of or Age at Diagnosis:	
Type(s) of thyroid cancer:	<input type="checkbox"/> Papillary or Papillary/follicular <input type="checkbox"/> Anaplastic <input type="checkbox"/> Follicular <input type="checkbox"/> Hurthle cell <input type="checkbox"/> Medullary <input type="checkbox"/> Unknown
What was the stage of the tumor?	
Is there a history of metastatic disease? If yes, provide details:	
Have any of the following treatments been given? Check all that apply:	<input type="checkbox"/> Surgery (if yes, describe) _____ <input type="checkbox"/> Radioisotope (I-131) treatment <input type="checkbox"/> Chemotherapy <input type="checkbox"/> External radiation treatment
Have any additional studies been completed? Check all that apply and provide date(s):	<input type="checkbox"/> Radioisotope scans _____ <input type="checkbox"/> Ultrasound _____ <input type="checkbox"/> Thyroglobulin _____ <input type="checkbox"/> Calcitonin _____
Medications currently being taken (provide dosage and frequency):	
Does the client currently smoke or ever smoked? If yes, provide date of last tobacco use:	
Has the client ever had any other major medical conditions? Provide diagnosis date, treatment, results, etc.	
Additional Information:	

Please return the completed form to your financial professional.

All quotes are tentative and are NOT BINDING and SUBJECT TO full underwriting which may include exams, labs, doctor records, and/or any other information obtained during the underwriting process.