

# MEDICAL HISTORY QUESTIONNAIRE: BREAST CANCER

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: ☐ Male ☐ Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Tobacco Usage: \_\_\_\_\_ Coverage Information: \_\_\_\_\_

☐ Never Type: ☐ Term ☐ UL ☐ IUL

☐ Former Date Stopped: \_\_\_\_\_ ☐ WL ☐ VUL ☐ Survivorship

☐ Current Type: \_\_\_\_\_ Face Amount: \_\_\_\_\_

Premium Tolerance: \_\_\_\_\_

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis \_\_\_\_\_

2. How was the cancer treated? (check all that apply)

☐ Excisional biopsy only ☐ lumpectomy or wide excision ☐ Mastectomy

☐ Radiation therapy ☐ Chemotherapy ☐ Hormonal therapy (tamoxifen)

3. Date treatment was completed: \_\_\_\_\_

4. What stage was the cancer?

☐ 0 - in situ ☐ I ☐ II ☐ III ☐ IV

5. Were any lymph nodes involved? ☐ No ☐ Yes

If yes, how many: \_\_\_\_\_

6. Has there been any evidence of recurrence? ☐ No ☐ Yes

If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Date and results of last mammogram: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 8. Please list current medications

Name of Medication	Dosage	Reason

9. Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes

If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_