Return to - jim@uswolfe.com or Fax to 815-377-3556

ELEVATED PROSTATE SPECIFIC ANTIGEN (PSA) QUESTIONNAIRE

Insured's Name: DOB: State: Sex: M / F

Height: Ft. In. Weight: Face Amount:

Tobacco use in the past 5 years: No Yes Details:

Producer: State: Phone: E-mail:

Proposed Insured please answer the following:

1. How long has the PSA been elevated?

2. What is the diagnosis?

3. Please give date and result(s) of most recent test(s):

4. Have these results been (please circle):
   Increasing Fluctuating Unknown
   Decreasing Stable

5. If any of the following have been done, please give the details and results:

   TRUS:

   PSAD:

   Free PSA:

   Prostate Biopsy:

6. Are you on any medications(s)? Yes No
   Name(s) and dosage(s):

7. List any other major health problems (i.e. heart disease, etc.):

8. Name, address & phone number of your physician(s) and date last consulted:

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____