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

PROSTATE CANCER 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. Date of your diagnosis:
2. Please give the name of the cancer and the location:
3. Please give Stage and Gleason Grade of tumor:
4. What symptoms did you have prior to your diagnosis:
5. Number of Lymph nodes involved:
6. How was/is the cancer treated (please circle all that apply)?
   Radiation Therapy Hormonal Immunotherapy
   Medication: Surgery Chemotherapy
7. Duration of treatment:
8. Date of your last treatment:
9. Date and result of your most recent PSA test:
10. PSA prior to treatment?
11. Was there any indication of the cancer spreading? Yes No
    Details:
12. Has there been any evidence of reoccurrence? Yes No
    Details:
13. Is there any family history of cancer? Yes No
    Details:
14. Are you on any medication(s)? Yes No
    Name(s) and dosage(s):
15. Name, address & phone number of your physician(s) and Oncologist and the date last consulted:
16. List any other major health problems (i.e. heart disease, etc.):

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

Date: ________________ Insured's Signature: ________________________________