



## Hepatitis Questionnaire

**Agent:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Client:** \_\_\_\_\_ **DOB :** \_\_\_\_\_  *Male*  *Female*  
**Product/Face Amount:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

\* **TOBACCO/NICOTINE USE (past or present):**  **YES\*\*\***  **NO**  
 \*\*\*Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:

\* **Date of Hepatitis diagnosis and circumstances/events surrounding diagnosis:**

\* **What form of hepatitis was diagnosed?**

- Hepatitis A*
- Hepatitis B, resolved or immune*
- Hepatitis B, carrier or chronic infection*
- Hepatitis C (non-A/non-B)*

\* **Was a cause of the hepatitis infection determined?**

- YES** (please indicate proposed cause)
- NO** – No cause established

\* **Date and results of the most recent liver enzyme and hepatitis infection blood studies:**

*AST (SGOT):*  
*ALT (SGPT):*  
*GGT (GGTP):*  
*Viral "load" studies (amount of virus in blood):*

\* **MEDICATIONS** - List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:

MEDICATION	DOSE	MEDICATION	DOSE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

\* **Do you currently consume alcoholic beverages?**

- YES** (please note amount, type and frequency)
- NO**

\*Which, if any, of the following studies have been completed or planned? If completed, please note if results were “normal” or “abnormal” and/or list any details you remember relative to your physician’s explanation of the results:

- Liver ultrasound or CT scan – **RESULT:** normal abnormal
- Liver biopsy – **RESULT:** normal abnormal
- No such tests have been performed or recommended
- Testing has been recommended, but not completed

\*Have you been diagnosed with “chronic” hepatitis or cirrhosis?

- YES - Please provide details:
- NO

\*Have you undergone or been advised to undergo treatment with Interferon or other anti-viral drugs?

- YES (List details; date, duration of treatment, treatment outcome)
- NO

\* **FAMILY HISTORY:** (Family history may be a factor in determining rate class) **Is there a family history (parent or siblings) of the following conditions/disease onset prior to age 60:**

- |                        |  |                 |  |
|------------------------|--|-----------------|--|
| <i>Cardiac Disease</i> | <input type="checkbox"/> YES <input type="checkbox"/> NO | <i>Diabetes</i> | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <i>Stroke or TIA</i>   | <input type="checkbox"/> YES <input type="checkbox"/> NO | <i>Cancer</i>   | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please provide details for any “YES” response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (if living)	DECEASED (list age @ time of death)
<i>FATHER</i>				
<i>MOTHER</i>				
<i>SIBLING 1</i>				
<i>SIBLING 2</i>				

\* Do you have any other significant health issues or medical conditions not outlined or mentioned on this form? (Complete additional questionnaires, as indicated)

- Condition(s) - List treatment and current status:
- NONE - NO other medical conditions or health issues.

\* Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.

\*Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?