CANCER QUESTIONNAIRE

Rohrer & Associates

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 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)?

Medication	Hormonal	Immunotherapy
Radiation Therapy	Surgery	Chemotherapy

7. Duration of treatment:

8. Date of your last treatment:

9. Was there any indication of the cancer spreading? Yes No
   Details:

10. Has there been any evidence of reoccurrence? Yes No
    Details:

11. Is there any family history of cancer? Yes No

12. Are you taking any medications? Yes No
    Name(s) and dosage(s):

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

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

Date: _____ Insured's Signature: _____