



## Leukemia

*Please answer all questions applicable to the client's medical history.*

Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Face Amount \_\_\_\_\_ Max Premium \$ \_\_\_\_\_ /yr.  Term  Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)?  Yes  No

Frequency \_\_\_\_\_ Date of last use \_\_\_\_\_ Type \_\_\_\_\_

Type of leukemia \_\_\_\_\_ Date of diagnosis \_\_\_\_\_ Date of treatment \_\_\_\_\_

Acute Lymphoid/Acute Myeloid (AML)  Chronic Lymphoid (CLL)  Hairy cell  Chronic Myeloid (CML)

Stage  0  I  II  III  IV

Type of Treatment \_\_\_\_\_

Evidence of recurrence, relapse, or related illness  Yes  No If yes, provide details \_\_\_\_\_

Has the client's spleen been removed as part of the treatment procedure?  Yes  No If yes, date \_\_\_\_\_

Most current blood count (CBC) readings  
Date \_\_\_\_\_ White blood cells \_\_\_\_\_ Hemoglobin \_\_\_\_\_ Platelets \_\_\_\_\_

How frequently does the client visit his/her health care provider for checkups including blood counts? \_\_\_\_\_

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: