

# Life Scan Questionnaire for **HEPATITIS (ELEVATED LIVER FUNCTIONS)**

## LIFE INSURANCE RISK EVALUATION AND MARKET SEARCH

For \_\_\_\_\_ [ ] Male [ ] Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ [ ] Non Smoker [ ] Smoker

Have you ever used tobacco? [ ] Yes [ ] No If yes, state month and year of last use of any tobacco product: \_\_\_\_\_

Type of tobacco used: [ ] Cigarettes [ ] Cigars [ ] Chews [ ] Pipe

Amt\$ \_\_\_\_\_ Type: [ ] Whole Life or Universal [ ] Term

Last application for life insurance: Year \_\_\_\_\_ Company \_\_\_\_\_

Result: [ ] Preferred [ ] Standard [ ] Rated/Rating \_\_\_\_\_ [ ] Declined

1. List date and results of the client's two most recent liver function tests:

	Result	Date # 1	Result	Date # 2
AST/SGOT	_____	_____	_____	_____
ALT/SGPT	_____	_____	_____	_____
GGTP	_____	_____	_____	_____
ALK PHOS	_____	_____	_____	_____
BILIRUBIN	_____	_____	_____	_____

2. Check type, then list date and results of recent hepatitis screening:

[ ] A Date \_\_\_\_\_ [ ] Neg [ ] Pos  
[ ] B Date \_\_\_\_\_ [ ] Neg [ ] Pos  
[ ] C Date \_\_\_\_\_ [ ] Neg [ ] Pos

3. Has the client had a liver Biopsy?

[ ] Yes [ ] No If Yes, please detail date and results:

\_\_\_\_\_

4. Has the client ever been diagnosed with:

Fatty Liver? [ ] Yes [ ] No If yes, please detail:

\_\_\_\_\_

Hepatitis? [ ] Yes [ ] No If yes, check type and detail:

[ ] Acute [ ] Chronic Active [ ] Chronic Persistent

Details: \_\_\_\_\_

Cirrhosis? [ ] Yes [ ] No

5. Does the client consume any type of alcoholic beverage?

[ ] Yes [ ] No If yes, please detail frequency and amount:

\_\_\_\_\_

If No, Date of last drink: Month \_\_\_\_\_ Year \_\_\_\_\_

6. Date of client's last visit to a physician:

[ ] 0 to 6 months ago [ ] 6 to 12 months ago

[ ] 12 to 24 months ago [ ] Over 2 year ago

### Life Factors

#### Date of last stress EKG

Month \_\_\_\_ Year \_\_\_\_ [ ] Never

**Family History**, has either parent or any sibling died before age 65?

[ ] Yes [ ] No If yes, please list cause and age.

\_\_\_\_\_

**Blood Pressure**, with or without medication \_\_\_\_\_ / \_\_\_\_\_  
List medication, if any

\_\_\_\_\_

Result of last **Cholesterol** test, if known \_\_\_\_\_

List all **Other Illnesses** not listed on this page.

\_\_\_\_\_

\_\_\_\_\_

List all medications currently being used except those previously listed.

(name, dosage and times per day)

\_\_\_\_\_

\_\_\_\_\_

### Agent Information

Name \_\_\_\_\_

Address \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_

ST \_\_\_\_ Zip \_\_\_\_ email \_\_\_\_\_

**LIFE INSURANCE SOLUTIONS**

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