Neoplasm Questionnaire

General Information

Last Name:	First Name:
Date of Birth:	Age: / Sex:
Height : Cm	Weight: Kg
Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes per day? If No, did you ever smoke? Yes ☐ No ☐	For how many years? When did you stop?
Name, address and telephone number of present attending Physician:	
Frequency of visits to physician:	Date of last visit: / /

Condition Profile

At what Age were you told you had a Cancer?

What was the type of cancer?		What was the stage?
☐ Lung ☐ Breast ☐ Prostate ☐ Colon ☐ Gastric ☐ Esophageal	☐ Bladder ☐ Hepatic ☐ Pancreatic ☐ Lymphoma ☐ Leukemia ☐ Other:----------	---------- ---------- ---------- What was the grade? ---------- ---------- ----------
Had the Cancer spread the original site or were the Lymph Nodes involved? Yes ☐ No ☐. If Yes, Please Explain: ---------- ---------- ---------- ---------- ----------		Has there been any evidence of Recurrence? Yes ☐ No ☐ If Yes, Please Explain: ---------- ---------- ---------- ---------- ----------

Treatment:

- Medications:
  - o
  - o
  - o
- Surgery Yes ☐ No ☐ Date __/__/____
  Procedure Type:
- Chemotherapy Yes ☐ No ☐ Date __/__/____
  Starting Date: ___/___/____ Last treatment: ___/___/____ Number of Cycles: ____
- Radiation Therapy Yes ☐ No ☐ Date __/__/____
  Starting Date: ___/___/____ Last treatment: ___/___/____ Number of Cycles: ____
- Hormonal Therapy Yes ☐ No ☐ Date __/__/____
  Starting Date: ___/___/____ Last treatment: ___/___/____ Number of Cycles: ____

Have you ever been hospitalized for cancer

Last Result of Tumor Markers

• AFP : ___ Date: __/__/____	• CA15-3: ___ Date: __/__/____
• HCG : ___ Date: __/__/____	• PSA : ___ Date: __/__/____
• CEA : ___ Date: __/__/____	• Other (Please Specify):_____
• CA19-9: ___ Date: __/__/_____	• Value: ___ Date: __/__/____

Please continue filling in the next page

Neoplasm Questionnaire (cont'd)

Please check the illnesses below that you have ever had:			
☐ Stroke	Year……	☐ Edema	Year……
☐ Heart Rhythm Problem	Year……	☐ Eye trouble	Year……
☐ Liver Problem	Year……	☐ Ulcer Disease	Year……
☐ Kidney Disease	Year……	☐ Other?.....	Year……

Do other members of your family have Cancer? Yes ☐ No ☐ (if a parent is deceased, please list the cause of the death)

If yes, who and what is the type?
-
-

Attending Physician:---------- Date ---------/----------/----------

I hereby, give full and irrevocable authorization to the Insuranec Company, to the Administrator and to MedNet Delegates' (Physician and Nurses), to inquire about my actual state of health and that of my dependants from any Medical Center or Hospital or Doctor, and I waive my right of medical confidentiality to the benefit of the Insurance Company, the Administrator and MedNet Delegates'. Failure to disclose material information, whether by omission or false declaration, which the Insurance Company should have known, the latter will have the right to cancel my or my dependents' rights in coverage starting from the effective date of the policy without having any financial obligation.

Insured's Signature:---------- Date ----------/----------/----------