NAILBA
NAILBA University

PHEOCHROMOCYTOMA

CLIENT NAME: ____ **Date:** _______________________

☐ Male ☐ Female Date of birth: ____________ Height: _____' _____" Weight: ____________

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: ____________ ☐ Use now Type of nicotine product: ______________

Type of Coverage: ☐Term ☐UL ☐ Survivor ☐ Disability **Coverage Amount:** ________________________

Annual Income:____________________ **Occupation/Job duties:** ______________________ **State of Residence:** __________________

Anticipated Premium: _________________________

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnosis? ____

☐ Benign vs. ☐ Malignant

☐ Single vs. ☐ Multiple

2. What evaluation was done? Please give date and results.

☐ MRI, CT Date: __________________________________ __________________________________

☐ Urine Test Date: __________________________________ __________________________________

☐ Blood Test Date: __________________________________ __________________________________

3. Has your client had surgery to remove a pheochromocytoma? ☐ No ☐ Yes; please give details

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4. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

5. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

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