

SICKLE CELL ANEMIA

CLIENT NAME:			Date:		
☐ Male ☐ Female Date of birth: Heig			Weight:		
Tobacco Use: □ Never used □ Totally stopped Date stopped: □ Use no				Type of nicotine product:	
Type of Coverage: ☐ Term ☐ UL	☐ Survivor T	ype of Coverage:	☐ Term ☐ UL	☐ Survivor UL	
Coverage Amount: Anticipated Premium:					
		FAMILY HI	STORY		
		who had cancer, d	iabetes, stroke, heart	or kidney disease or who committed suicide? fonset and date of death	
	PROPOSE	D INSURED'S EXI	STING INSURANCE		
Full Name of Company Face Amo		nt	Year Issued Is Policy to be Replaced?		
1. Date of diagnosis:					
□ Sickle cell (SS) □ Sickle cell (SC) □ Sickle cell trait (SA) □ Hemoglobin C 3. Is there a history of complications? □ Painful crisis Date: □ Aaseptic necrosis of bones Date: □ Leg ulcers Date: □ Lung scarring Date: □ Thrombosis Date: □ Enlarged heart Date: □ Other:				date of the last episode.	
4. What is the current hemoglobin?				_	
5. Is client taking any medication, includi	ng inhalers? (accur	ate name, dosage	, and reason)		
(Accurate) Name of Medication		Dosage	Reason		
6. Are there any other health problems? (additional question	naires may be rec	quired) □ No □ Y	'es; please give details	