



Hepatitis

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 _____

Date of diagnosis _____

How was the client infected? _____ Current symptoms _____

The hepatitis has been diagnosed as

- | | |
|--|---|
| <input type="checkbox"/> Acute Viral Hepatitis A Resolved | <input type="checkbox"/> Hepatitis A Unresolved |
| <input type="checkbox"/> Acute Viral Hepatitis B Resolved | <input type="checkbox"/> Chronic Persistent Hepatitis B Unresolved (e.g. carrier) |
| <input type="checkbox"/> Chronic Active Hepatitis B Unresolved | <input type="checkbox"/> Acute Viral Hepatitis C |
| <input type="checkbox"/> Chronic Persistent Hepatitis C | <input type="checkbox"/> Chronic Active Hepatitis C |
| <input type="checkbox"/> Other _____ | |

Most current liver enzyme levels

Date	GGTP	ALT/SGPT	AST/SGOT	HBV RIBA	Anti HCV	HCV Viral Load	HB Viral Load

Which studies have been done to diagnose/treat the condition

- | | | | |
|--|------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Liver ultrasound | Date _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> CT scan | Date _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> MRI | Date _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Biopsy | Date _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Studies recommended/pending _____ | | | Date planned _____ |

Has the client been treated for hepatitis? Yes No If treated, Begin date _____ End date _____

List all medications including those used in treatment _____

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

List any other major health problems the client has: