# Hemophilia Questionnaire

**Name _____ Sex M F Date of Birth _____**

**Height _____ Weight _____ Smoker? Y N State _____**

**Plan of Insurance Desired? _____ Face Amount _____**

**Have you ever been Rated or Declined for insurance? If YES Complete details please**

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**When was your Disease first diagnosed? _____**

**Have you been diagnosed as having: Hemophilia A Hemophilia B Von Willebrand's Disease**

**How often do you visit your doctor? _____ Date of last visit _____**

**What symptoms have you exhibited? _____**

**How is your Disease being treated? _____**

**Are you on a regular program of Prophylaxis? _____**

**Please list all medications being taken: _____**

**_____**

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**Do you have any other major health problems? (example: aids, cancer, cardiovascular, etc)?**

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## Broker Submitting Questionnaire:

**_____**

**Address _____**

**Phone: _____ FAX: _____ E-mail: _____**

**Please send completed form: Victorson Associates, Inc. PO Box 863 Smithtown, NY 11787**

**You may Fax to: (631) 265-7054 or E-mail to: vainc@victorson.com**