## **Peripheral Vascular Disease**

Please answer all questions applicable to the client's medical history.

Producer Name Pr	none	Date		
Client Name Date of Birth		Male Female		
Face Amount Max Premium \$ /yr.				
Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? 🗌 Yes 🗌 No				
Frequency Date o	f last use	Туре		
te of diagnosis Artery(s) involved				
Location				
Select the treatments the client has had Angioplasty; date Bypass grafting; date				
Are any of the following present (select all that apply)           Bruit heard by physician         Diminished pulses           Claudication pain with activity         Ankle - brachial blood pressure ratio (if yes, send copy of results)				
Has the client had any of the following (select all that apply) Abnormal lipid levels Chest pain Ch			☐High blood pressure □Cerebrovascular or carotid disease	
Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken	

List any other major health problems the client has:

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