Peripheral Vascular Disease

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_____ Artery(s) involved_____

Location
☐Legs ☐Arms

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 ☐Diabetes ☐High blood pressure
☐Chest pain ☐Coronary artery disease ☐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: