THROMBUS (HYPERCOAGULABLE CLOTTING DISORDER)

CLIENT NAME: _____ **Date:** _____
☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____
Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____
Type of Coverage: ☐ Term ☐ UL ☐ Survivor   **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL
Coverage Amount: _____   **Anticipated Premium:** _____

FAMILY HISTORY
Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?
If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnosis: _____

2. Note the type of treatment:
☐ Coumadin
☐ Aspirin
☐ Heparin
☐ Hospitalization Date: _____

3. Was there a Thromboembolic event?
☐ MI
☐ DVT
☐ CVA
☐ PE
☐ Other _____
☐ None

4. Has there been any evidence of recurrence?   ☐ No ☐ Yes; please give details

_____
_____

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. Are there any other health problems? (additional questionnaires may be required)   ☐ No ☐ Yes; please give details

_____
_____