



Blood Clots

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 _____

Cause of blood clot

- Atrial Fibrillation Travel Sedentary Lifestyle
 PFO (Patent Foramen Ovale) ASD (Atrial Septal Defect) Post-Operative Complication
 Other _____

Clotting Disorder

- Factor V Leiden Resistance Lupus Anticoagulant Antiphospholipid Antibody
 Other _____

Date of first diagnosis _____

Type of treatment

- Blood thinner (coumadin); date(s) _____
 Aspirin; date(s) _____
 Hospitalization; date(s) _____

Any evidence of recurrence Yes No If yes, provide dates/details _____

Have any of the following occurred due to blood clots

- Heart attack Stroke Deep vein thrombosis (DVT) Pulmonary embolism
 Other _____

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

List any other major health problems the client has:

Questions?

Please call your McGill Brokerage Marketing Team at 800-279-0751.