



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:

Questions?

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