



Deep Vein Thrombosis Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/ F

Tobacco Usage: _____

Face Amount: _____

State of Residence: _____

___Term 10 15 20 30 ___UL

1. When was the proposed insured diagnosed? _____

2. Does the proposed insured experience any of the following symptoms: (Check all that apply)

___Swelling ___Warmth ___Pain or tenderness ___Redness

3. Has the proposed insured ever suffered from a pulmonary embolism? ___Yes ___No

(If yes, please provide date/details): _____

4. Please provide the location, date, and treatment of any blood clots:

Date: _____ Location: _____ Treatment: _____

Date: _____ Location: _____ Treatment: _____

Date: _____ Location: _____ Treatment: _____

Date: _____ Location: _____ Treatment: _____

Date: _____ Location: _____ Treatment: _____

5. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No

(If yes, please provide the name, dosage, and frequency):

