

Deep Vein Thrombosis Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M F

Tobacco Usage: _____ Face Amount: _____

State: _____ ___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 the 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: _____

