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: