Carotid Artery Stenosis

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 _____

Does the client have a history of Carotid Bruit (noise heard on examination due to turbulent blood flow in the carotid artery) ☐Yes ☐No

Is the client diagnosed with single or bilateral carotid stenosis?_____

If known, percentage on right side_____ Percentage on left side_____

Provide date of last Carotid ultrasound_____

Has the client had an Endarterectomy (removal of carotid plaque) or stenting for carotid stenosis ☐Yes ☐No

If yes, which method of treatment did he/she have_____ Date of procedure_____

Does the client take Anticoagulants/blood thinning medication (e.g. Aspirin, Coumadin) ☐Yes ☐No

Does the client have a history of any of the following:

High blood pressure ☐Yes ☐No If yes, provide a recent reading (if known)_____

High Cholesterol ☐Yes ☐No Total Cholesterol_____ HDL _____Triglycerides _____

Diabetes ☐Yes ☐No If yes, what type ☐Type 1 ☐Type II Date diagnosed_____Recent A2C level_____

TIA (transient ischemic attack) ☐Yes ☐No If yes, provide date_____

Stroke ☐Yes ☐No If yes, provide date_____Provide details of any residual impairment caused by the stroke (e.g. paralysis, weakness, other)_____

Blood Clot ☐Yes ☐No If yes, provide date(s) & details_____

Peripheral Vascular Disease ☐Yes ☐No If yes, provide details with date(s) and any treatment (e.g. stent, bypass surgery, other)

_____

Coronary Artery Disease ☐Yes ☐No If yes, provide details with date(s) and any treatment (e.g. stent, bypass surgery, other)

_____

Heart Attack ☐Yes ☐No If yes, provide details with date(s) and any treatment (e.g. stent, bypass surgery, other)

_____

Has the client ever had a stress test Yes No If yes, provide date_____ Test results _____

Is there a family history of cardiac or vascular disease? ☐Yes ☐No If yes, provide the details of whom, what condition, their age of onset, age at death (if applicable)_____

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

List any other major health problems the client has:

For Insurance Professional Use Only. Not intended for use in solicitation of sales to the public. Not intended to recommend the use of any product or strategy for any particular client or class of clients. For use with non-registered products only. Products and programs offered through Tellus are not approved for use in all states. July 31, 2017

Powered by Tellus BROKERAGE CONNECTIONS

Copyright © 2017 Tellus Brokerage Connections