



Phlebitis 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)
___Redness and Swelling at problem area ___Warmth ___Pain or tenderness

3. Has the proposed insured ever required surgery and/or hospitalization for this condition?
____Yes ____No (If yes, please provide dates and surgery/treatment received)

4. Is the proposed insured taking any medication for this condition or any other? ____Yes ____No
(If yes, please provide the name, dosage, and frequency):

