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):
_____
_____
_____
_____

BSI (800) 229-9020 Local (301) 540-8484 Fax (301) 540-8787