Peripheral Vascular Disease Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 ___UL

1. Date of first diagnosis: _____

2. What condition(s) have been diagnosed?
___Peripheral arterial disease ___Atherosclerosis ___ Peripheral Venus disorder

3. If diagnosed with Peripheral arterial disease, which of the following type?
___Carotid Artery Disease ___Peripheral Arterial Disease ___Abdominal aortic aneurysm
___Reynaud Syndrome ___Bueger Disease ___Polyarteris nodosa

4. If diagnosed with Peripheral venous disorders, which of the following type?
___Thrombophlebitis ___Varicose Veins ___Chronic venous insufficiency

5. Does the proposed insured have any of the following symptoms? (Check all that apply)
___Claudication ___Buttock Pain ___Numbness or tingling ___Change in skin color
___Impotence ___Infection/sores that do not heal

6. Has surgery been recommended or performed?
(If yes, please list dates and type of surgery)
_____
_____
_____

7. Has the proposed insured ever been disabled because of the condition?
(If yes, please provide dates): _____

8. Is the proposed insured taking any medications? _____Yes _____No
(If yes, please provide name, dosage, and frequency)
_____
_____
_____
_____

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