J.L.Thomas & Company

A LIFEMARK PARTNER

The strength of many. The power of one.

Peripheral Vascular Disease - Ask "Rx" pert underwriter
(ask our experts)

Producer _____ Phone _____ Fax _____

Client _____ Age/DOB _____ Sex _____

1. Please list date of diagnosis and artery(ies) involved:

_____

2. Has your client had any of the following treatments? (if yes, please note date
   - ☐ angioplasty _____(date)
   - ☐ bypass grafting _____(date)
3. Are any of the following present (check all that apply
   - ☐ bruit heard by physician
   - ☐ diminished pulses
   - ☐ claudication pain with activity
   - ☐ ankle - brachial blood pressure ratio (if yes, please send copy of results)
4. Is your client on any medication
   - ☐ yes, please give details _____
   - ☐ no
5. Please check if your client has had any of the following: (check all that appl
   - ☐ abnormal lipid levels
   - ☐ high blood pressure
   - ☐ coronary artery disease
   - ☐ diabetes
   - ☐ chest pain
   - ☐ cerebrovascular or carotid disease
6. Has your client smoked cigarettes in the last 12 month
   - ☐ yes, please give details _____
   - ☐ no
7. Does your client have any other major health problems (ex: canc , etc.)?
   - ☐ yes, please give details _____
   - ☐ no