

# THROMBUS (HYPERCOAGULABLE CLOTTING DISORDER)

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

## FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
**If yes, use separate sheet to provide this information, including age of onset and date of death**

| PROPOSED INSURED'S EXISTING INSURANCE |             |             |                           |
|---------------------------------------|-------------|-------------|---------------------------|
| Full Name of Company                  | Face Amount | Year Issued | Is Policy to be Replaced? |
|                                       |             |             |                           |
|                                       |             |             |                           |

1. Date of diagnosis: \_\_\_\_\_

2. Note the type of treatment:

Coumadin

Aspirin

Heparin

Hospitalization Date: \_\_\_\_\_

3. Was there a Thromboembolic event?

MI

DVT

CVA

PE

Other \_\_\_\_\_

None

4. Has there been any evidence of recurrence?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

| (Accurate) Name of Medication | Dosage | Reason |
|-------------------------------|--------|--------|
|                               |        |        |
|                               |        |        |
|                               |        |        |

6. Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

