

Underwriting Questionnaire

Carotid Artery Stenosis

Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____

Male Female Face Amount _____ Max Premium \$ _____ /yr.

Term Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? Yes No

Frequency _____ Date of last use _____ Type _____

Does the client have a history of Carotid Bruit (noise heard on examination due to turbulent blood flow in the carotid artery) Yes No

Is the client diagnosed with single or bilateral carotid stenosis? _____

If known, percentage on right side _____ Percentage on left side _____

Provide date of last Carotid ultrasound _____

Has the client had an Endarterectomy (removal of carotid plaque) or stenting for carotid stenosis Yes No

If yes, which method of treatment did he/she have _____ Date of procedure _____

Does the client take Anticoagulants/blood thinning medication (e.g. Aspirin, Coumadin) Yes No

Does the client have a history of any of the following:

High blood pressure Yes No If yes, provide a recent reading (if known) _____

High Cholesterol Yes No Total Cholesterol _____ HDL _____ Triglycerides _____

Diabetes Yes No If yes, what type Type I Type II Date diagnosed _____ Recent A2C level _____

TIA (transient ischemic attack) Yes No If yes, provide date _____

Stroke Yes No If yes, provide date _____ Provide details of any residual impairment caused by the stroke (e.g. paralysis, weakness, other) _____

Blood Clot Yes No If yes, provide date(s) & details _____

Peripheral Vascular Disease Yes No If yes, provide details with date(s) and any treatment (e.g. stent, bypass surgery, other) _____

Coronary Artery Disease Yes No If yes, provide details with date(s) and any treatment (e.g. stent, bypass surgery, other) _____

Heart Attack Yes No If yes, provide details with date(s) and any treatment (e.g. stent, bypass surgery, other) _____

Has the client ever had a stress test Yes No If yes, provide date _____ Test results _____

Is there a family history of cardiac or vascular disease? Yes No If yes, provide the details of whom, what condition, their age of onset, age at death (if applicable) _____

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: