

Peripheral Vascular Disease (Claudication)

Name _____ Sex M F Date of Birth _____

Height _____ Weight _____ Smoker? Y N State _____

Coverage Desired? _____ Amount _____ Plan Desired? _____

Have you ever been Rated or Declined for insurance? If YES Complete details please

When was the Peripheral Vascular Disease first diagnosed? _____

Date of onset of condition, duration, severity, location? _____

Was it associated with exercise, exertion, excitement, any other circumstance? _____

How has it been treated? _____

Has treatment been completed? If YES, When? _____

Have you ever had or been treated for: (Please Circle all that apply)
Chest Pain or Coronary Coronary Artery Disease TIA or Stroke
Enlarged heart Kidney Disease Aneurysm
If YES, Complete details please _____

Have you had a Treadmill EKG or any type of Stress Test? If so, When? _____
Were the results normal? _____

What have been your recent Blood Pressure readings? _____

What has been your recent Cholesterol readings? _____

Do you have Diabetes? Y N When Diagnosed? _____
If YES, what medication are you taking? _____

Do you have any Family History of Heart Disease. Peripheral Vascular Disease or Diabetes? Y N
If YES, Complete details please _____

What Lifestyle Changes have you made to treat your illness? _____

Please list all medications being taken: _____

Do you have any other major health problems? (example: cancer, etc)? _____

Broker Submitting Questionnaire: _____

Address _____

Phone: _____ FAX: _____ E-mail: _____

Please send completed form: Victorson Associates, Inc. PO Box 863 Smithtown, NY 11787
You may Fax to: (631) 265-7054 or E-mail to: vainc@victorson.com