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 1 ☐ 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:

Tellus SM