Return to - jim@uswolfe.com or Fax to 815-377-3556

# PERIPHERAL VASCULAR DISEASE/NEUROPATHY

Insured's Name: DOB: State: Sex: M / F

Height: Ft. In. Weight: Face Amount:

Tobacco use in the past 5 years: No Yes Details:

Producer: State: Phone: E-mail:

Proposed Insured please answer the following:

1. Have you been diagnosed with any of the following (circle all that apply):
   - Peripheral Vascular Disease
   - ASO (Arterio Sclerosis Obliterans)
   - Abdominal Aneurysm
   - Vascular Aneurysm
   - Leriche's Syndrome
   - Claudication
   - Cerebral Aneurysm
   - Other disorder of the circulatory system
2. When were you diagnosed?
3. What were your first symptoms?
4. Please indicate dates and tests that have been completed to give you this diagnosis?
   - Date: Test:
   - Results:
   - Date: Test:
   - Results:
   - Date: Test:
   - Results:
   - Date: Test:
   - Results:
5. Have any of the following surgeries been suggested or done? Date:
   - Aorta Femoral Bypass (leg vessels)
   - Endarterectomy (clean arteries)
   - Aneurysmotomy (repair of an aneurysm)
   - Other surgical procedure Details:
6. What were the results of the surgery(ies)?
7. Do you have any other major health problems? No Yes
   Details:
8. Are you on any medication(s)? No Yes
   Name(s) and dosage(s):
9. Name and address of your physician(s) and date(s) last consulted:

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____