Raccuglia Financial Brokerage, Inc.
"Commitment to Integrity & Service"
13220 Metcalf Ave Suite 160 Overland Park, Ks. 66213
913-385-9050 or 800-842-7324 fax: 913-385-9055
Email: david@rfb-inc.com

Agent / Agency: _____Phone# _____
Email address: _____ Fax: _____

Client Name: _____M_____F_____State: _____DOB/Age: _____
Height: _____Weight: _____Tobacco: ____Y_____N Type: _____
Type of Insurance: _____(Term / UL / WL)

Diabetes:
Type I ____ Type II _____ When diagnosed: _____ Current A1c: _____
Oral Med: _____Y Insulin: ____Y ____N If Yes, # of units per day: _____
Any Impairments: _____Eyes _____Neuropathy _____Amputations

Heart Disease: *When diagnosed: _____Heart Attack: ____Y _____N Mild ____ Mod._____*
Bypass Surgery: ____Y _____N # of vessels: _____ Angioplasty: ___Y __ N # stents placed: _____
Preceding conditions: Blockage _____ Chest Pain: _____ Irreg. EKG: _____ Fatigue: _____
Approx. date of last Stress Test: _____

Cancer: *When diagnosed: _____ Date of Clearance: _____ Treatment: _____*
Prostate: *_____Stage _____Gleason Score _____PSA prior to treatment*
Current reading: _____ Prostate removed: ____Y____N Radiation: _____ Y_____N
Skin Cancer: *Type: _____Stage: _____Clark's level: _____(if Melanoma)*
Breast Cancer: *Stage: _____Treatment: _____lymph nodes: _____Y _____N*
Date of last treatment: _____ (Note: Pathology report will have all pertinent information related any Cancer Type of Impairment, if can be secured by Client from Oncologist)

Stroke: *Date: _____ Cause: _____ Treatment: _____*
Residuals: _____Y _____N Slurred speech: ___Y ___N Loss / Restriction of limb use: ___Y ___N
Previous Strokes: _____Y _____N If yes, how many & when: _____

Depression: *When diagnosed: _____ Situational: _____ Bi-Polar: _____ PTSD: _____*
Suicide ideations: ___Y ___N Hospitalizations: ___Y ___N If yes, date: _____
Therapist: ____Y ____N How often: _____ Date of last visit: _____
Currently able to work: ____Y ____N On Disability: _____Y _____N

Pain: *When Diagnosed: _____Cause: _____ Location: _____*
Treatment: _____Medication (s): _____

Other Impairments: _____

Medications: _____

_____