RACCUGLIA FINANCIAL BROKERAGE, Inc.
"Commitment to Integrity & Service"
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QUICK QUOTE TO: quickquote@rfb-inc.com or fax: 913-385-9055

Agent / Agency: ______________________________Phone: ______________________fax : ________________
Email address: _______________________________ State: _______________________

Client Name: _______________________________M.____ F____ State: ________ DOB_______________
Height: __________Weight: _________Tobacco: ___Y ___N TYPE: _____________Insurance Amt: ___________

Diabetes: *Type I ____Type II ____ When Diagnosed: ______________ Oral med. _______ Insulin: ________*
If Insulin: __________units per day A1c reading: _____________Approx. date: ________________
Impairments: _____Eyes ______Neuropathy _____Amputations _____Skin ulcerations ____ Protein in urine

Heart Disease: *When diagnosed: ____________Heart Attack: ____Y _____N Mild or Mod. ___________*
ByPass Surgery: ____Y _____N How many vessels: ______ AngioPlasty: ____Y ____N #Stents placed: ______
Conditions preceding procedure: ____Heart attack ____Chest pain ____Irreg. EKG _____Extreme fatigue:
Approx. Date of Last Stress Test: _________________

Cancer: *When Diagnosed: _________________ Type: _________________ Treatment: ___________________*
Prostate: Stage: ___________ Gleason Score: ______________ Current PSA reading: ________
Skin Cancer: Type: _______________________ Stage: ____________ Clark's level: ____________(if Melanoma)
Breast Cancer: Stage: ______Treatment: _____________________________Lymph Node: ____Y _____N
Approximate date of last treatment: ______________________ (NOTE: Secure Pathology Report if possible)

Stroke: *Date: _______________ Cause: ________________Treatment: ____________________________*
If Carotid Artery: Surgery: _____Y _____N If yes, Date: _________________ Percent of blockage: _________
Residuals: _____Y _____N Slurred Speech: ____Y ____N Loss or Restriction of Limb use: ____Y _____N
Number of Strokes in past 24 months: _________none ______One _______two or more

Depression: *When diagnosed: _______________Situational: ____BiPolar ____ Anxiety ___PTSD ____*
Suicide attempts:? _____Y _____N Hospitalized? ___Y ____N If so, Date & how long: ____________________
Currently seeing Therapist: ____Y ____N Frequency: __________________ Last Visit: ___________________
Currently able to work: ___Y ____N

Pain: *Diagnosed: ________________Cause: _______________________Location of pain: __________________*
Treatment: ____________________________ Medication(s): ____

Other Impairments (Describe with as much information as possible): ___________________________________
____
____

All Current Medications: ____
____
____