

CHOLESTEROL

AGENT NAME: _____

CLIENT NAME: _____ Date: _____

1. Age of Onset: _____

2. When Diagnosed: _____

3. Current treatment - Medication and dosage.

(Accurate) Name of Medication	Dosage	Reason

4. What was your cholesterol reading upon onset? _____

5. What is your current cholesterol reading and HDL ratio? _____

6. Is there a family history of elevated cholesterol or heart disease? _____

7. Is there a family history of elevated cholesterol or heart disease? _____

Save and Email Completed Form to: quotes@levelfourinsurance.com

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