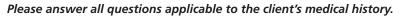
Kidney Transplant



Producer Name	Pho	one	Date			
Client Name	Date of Birth		Male Female			
Face Amount	Max Premiur	n \$ /yr.	Term Permanent			
Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? \Box Yes \Box No						
Frequency	Date of	last use	Туре			
Date(s) of transplant(s)						
Glomerulonephritis	Polycystic kidney disea	se natosis				
	esults	Serum creatinine Urinalysis				
Select all that have occurred Cancer Cardiovascular disease Disease recurrence Frequent infection High blood pressure Rejection episodes Toxicity from treatment	Date Det Date Det Date Det Date Det Date Det Date Det	ails ails ails ails ails ails				
Date of last appointment with Nep	phrologist					

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has:

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