

CORONARY QUESTIONNAIRE

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(ALWAYS Submit Pages 1 and 2)

Proposed Insured's Name: _____ DOB: _____ Sex: M F
Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
Broker's Name: _____ Face Amount: _____
BGA: _____ Phone: _____ Fax: _____

Proposed Insured please answer the following:

1. Have you had any of the following?

- Chest pain or Angina Dates: _____
 Heart attack(s) (MI) Dates: _____
 Bypass surgery(ies) (CABG) Dates: _____ How many vessels?
 Angioplasty(ies) (PTCA)* Dates: _____ How many vessels?
 Atherectomy(ies)* Dates: _____ How many vessels?

*If Stents were placed at the time of PTCA or Atherectomy: How many, per date?

- Heart valve disease
 Abnormal heart rhythm or pulse
 Abnormal EKG (electrocardiogram)
 Heart murmur

If surgery was done or is expected, for any of the above, please give details:

- Atrial fibrillation or flutter: Chronic (permanent) OR Paroxysmal (intermittent)
(fast heartbeat)

- Cause: Cardiomyopathy Heart valve disease
 Alcohol Coronary heart disease Thyroid disease
 Unknown or other:

- Symptoms: Black-out Palpitations
 Chest discomfort Dizziness (lightheadedness)/ faint feeling

-What was used to get the heart back to the normal rhythm?

- Date: _____ Method used: _____
Date: _____ Method used: _____
Date: _____ Method used: _____
Date: _____ Method used: _____

Extra heart beats: Details: _____

Any other heart problems: Details: _____

2. Please provide details for any checked box above:

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3. Have any of the following test(s) been completed?

- | | | |
|--|-------|----------|
| <input type="checkbox"/> Thallium stress ECG | Date: | Results: |
| <input type="checkbox"/> Stress echocardiograms | Date: | Results: |
| <input type="checkbox"/> Coronary Angiography | Date: | Results: |
| <input type="checkbox"/> Echocardiogram | Date: | Results: |
| <input type="checkbox"/> Chest X-ray | Date: | Results: |
| <input type="checkbox"/> Others (Details below): | Date: | Results: |

4. If you have had Angina, MI, PTCA or CABG, have you had a follow-up stress (exercise) EKG?

- No
- Yes, the results were normal. Date:
- Yes, the results were abnormal. Date:

5. Have you had any chest discomfort since the MI, PTCA or CABG? No Yes, Details:

6. Please list any medications you are currently taking, and explain reason for use:

7. Do you exercise on a regular basis? No Yes, Details:

8. Have you had any of the following? (If yes, please complete any/all appropriate questionnaires.)

- Diabetes High blood pressure Elevated cholesterol Cancer Overweight

Family history of heart disease (nearest relatives):

- | | | | |
|---------------|------|-----------------------------------|-----------------------------------|
| Relationship: | Age: | <input type="checkbox"/> Living / | <input type="checkbox"/> Deceased |
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| Relationship: | Age: | <input type="checkbox"/> Living / | <input type="checkbox"/> Deceased |
| Relationship: | Age: | <input type="checkbox"/> Living / | <input type="checkbox"/> Deceased |

9. Name and address of your cardiologist and physician(s):

10. Has case been shopped elsewhere, if so where?

11. Clients occupation

12. Ejection Fraction

Date: _____
