



## CORONARY QUESTIONNAIRE

### PAGE 1

(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: \_\_\_\_\_  
 Address: \_\_\_\_\_ 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: (fast heartbeat)       Chronic (permanent)      OR       Paroxysmal (intermittent)

- 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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## PAGE 2

(ALWAYS Submit Pages 1 and 2)

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