STENT QUESTIONNAIRE

Completing this questionnaire will assist your agent in determining the best carrier for your medical history

Agent Name: ____________ Agent Phone: ____________ Agent Email: ____________

Client Name: ____________ ❒ Male ❒ Female DOB: ___/___/___

Current Age: ____________ Height: ____________ Weight: ____________

1. Have you had weight changes in excess of 10 pounds in the last 12 months? ❒ Yes ❒ No

2. Do you have any family history of cancer, diabetes, or heart disease?

❒ No ❒ Yes Onset Age: ______ Current Age: ______ Age if Death Occurred: ______

If yes, please provide details: ____________

3. In the last 5 years, have you used any form of tobacco?

❒ No ❒ Yes (Please provide type & date last used): ____________

4. Any moving violations within the last 5 years? ❒ No ❒ Yes (Provide details)

____

5. Please list current medications (including inhalers). Please list dosage & frequency:

____

6. Do you have any other major medical issues? (heart disease, cancer, etc.) ____________

7. When was your stent put in? ____________

Contact information of cardiologist who performed the procedure:

Name of facility ____________ Name of doctor ____________

Phone number ____________ Address ____________

8. Which vessels were stented? ____________

9. What was the % of the blockage? ____________

10. What was the cause of the blockage? ____________

11. Was there a heart attack prior to or after the stent? ❒ No ❒ Yes (Provide details)

____

Contact information for the attending cardiologist:

Name of facility ____________ Name of doctor ____________

Phone number ____________ Address ____________

12. When was the last imaged stress test completed? ____________

Contact information for the cardiologist:

Name of facility ____________ Name of doctor ____________

Phone number ____________ Address ____________

13. Do you have any related medical problems? ❒ No ❒ Yes (Details)

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____

14. Other considerations: ____________

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Please fax to 612-392-7644 or email to mvp@mvpservicesolutions.com