

# Coronary Disease Questionnaire

Agent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:      Male / Female     

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ State: \_\_\_\_\_ Smoker:      Y / N      Face Amount: \_\_\_\_\_

Type of Insurance:      Universal Life      Whole Life      Survivorship      Term (# of years     )

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1. Has the proposed insured had any of the following?

<input type="checkbox"/> Chest Pain	Dates: _____
<input type="checkbox"/> Heart attack	Dates: _____
<input type="checkbox"/> Bypass surgery	(Complete the Bypass/Angioplasty/Stent Questionnaire.)
<input type="checkbox"/> Angioplasty	(Complete the Bypass/Angioplasty/Stent Questionnaire.)
<input type="checkbox"/> Atherectomy	Dates: _____ How many vessels: _____
<input type="checkbox"/> Stents	(Complete the Bypass/Angioplasty/Stent Questionnaire.)
<input type="checkbox"/> Heart Valve replacement	(Complete the Heart Valve Replacement Questionnaire.)
<input type="checkbox"/> Abnormal heart rhythm or pulse	Dates: _____
<input type="checkbox"/> Abnormal EKG	Dates: _____
<input type="checkbox"/> Heart Murmur	(Complete the Heart Murmur Questionnaire.)
<input type="checkbox"/> Atrial fibrillation	(Complete the Atrial Fibrillation Questionnaire.)
<input type="checkbox"/> Congestive heart Failure	Dates: _____

2. Has surgery been done or is it expected for any of the above?      Yes      No

If yes, provide details and dates:

3. If surgery has not been done or recommended, how is the proposed insured being treated?

3. Have any of the following tests been completed:

<input type="checkbox"/> Thallium Stress ECG	Date: _____	Results: _____
<input type="checkbox"/> Echocardiogram	Date: _____	Results: _____
<input type="checkbox"/> Angiography	Date: _____	Results: _____
<input type="checkbox"/> Stress Echocardiogram	Date: _____	Results: _____
<input type="checkbox"/> Chest X-ray	Date: _____	Results: _____
<input type="checkbox"/> Other _____	Date: _____	Results: _____

4. If the proposed insured had angina, heart attack, angioplasty or bypass, has a follow-up stress EKG been done?

     Yes, results were normal.      Yes, results were abnormal.      No

Details:

5. Has the proposed insured had any chest discomfort since the heart attack, angioplasty or bypass?      Yes      No

Details:

6. Is the proposed insured taking any medication(s)?      Yes      No

If yes, provide name, dosage and frequency of medication(s):