

**Coronary Questionnaire**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: M F

Tobacco Usage: \_\_\_\_\_ Face Amount: \_\_\_\_\_

State: \_\_\_\_\_ Term 10 15 20 30 \_\_\_\_\_UL

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

- Chest Pain Dates: \_\_\_\_\_
- Heart attack Dates: \_\_\_\_\_
- Bypass surgery Dates: \_\_\_\_\_ How many vessels: \_\_\_\_\_
- Angioplasty Dates: \_\_\_\_\_ How many vessels: \_\_\_\_\_
- Atherectomy Dates: \_\_\_\_\_ How many vessels: \_\_\_\_\_
- Stents Dates: \_\_\_\_\_ How many: \_\_\_\_\_
- Heart Valve disease
- Abnormal heart rhythm or pulse
- Abnormal EKG
- Heart Murmur
- Atrial fibrillation

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

If yes, please provide details and dates: \_\_\_\_\_

\_\_\_\_\_

3. Have any of the following tests been completed:

- Thallium Stress ECG Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Echocardiogram Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Angiography Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Stress Echocardiogram Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Chest X-ray Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Other \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

4. If the proposed insured had Angina, heart attack, angioplasty or bypass, have they had a follow-up stress EKG?

No  Yes, results were normal  Yes, results were abnormal

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:  Yes  No

If yes, please provide name, dosage and frequency: \_\_\_\_\_

\_\_\_\_\_