



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?

- Thallium stress ECG Date: Results:
- Stress echocardiograms Date: Results:
- Coronary Angiography Date: Results:
- Echocardiogram Date: Results:
- Chest X-ray Date: Results:
- 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 |
| Relationship: | Age: | <input type="checkbox"/> Living / | <input type="checkbox"/> Deceased |

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

Underwriter's Notes:

Date: _____ Proposed Insured's Signature: _____