☐ 1701 Research Boulevard
Rockville, Maryland 20850-3191

☐ 100 Quentin Roosevelt Boulevard, PO Box 519
Garden City, New York 11530-9641

CHEST PAIN QUESTIONNAIRE

(TO BE COMPLETED BY THE PROPOSED INSURED)

Name ______________________________ Date of Birth ______________________
(MO. DAY YR.)

1. Have you ever had: chest pain?________ palpitation?________ skipping of heart?________ shortness of breath?________

2. Did it involve: a sense of pressure or constriction?________ a burning sensation?________ sharp pain?________ aching?________ sweating?________

3. Date of onset, duration, severity, location. Was it associated with exertion, exercise, excitement or other circumstances?
   Give details ____
   ____
   ____
   ____

   If more than one attack, give frequency, duration, and date of last attack ______________________
   ____

4. What diagnosis was made concerning your symptoms: myocardial infarction?__________ coronary occlusion?__________ coronary insufficiency?__________ angina pectoris?__________ other?______________________

5. Were you: given emergency medical care?________ hospitalized?______________________

6. Date of return to work:________________ Any restrictions on activities?______________________

7. What medicines are you taking now? ____
   ____

8. Names and addresses of all physicians consulted since onset of chest pain: ______________________
   ____
   ____
   ____
   ____

I hereby declare that the above statements are complete and true to the best of my knowledge and belief.

Signature of
Proposed Insured______________________________ Witness______________________________

Date______________________________

LU-1193 (2/97)