Coronary Artery Disease Questionnaire

PLEASE PRINT

1 Name of Proposed Insured ____________________ Date of Birth ____________

2 Name and address of cardiologist or other doctor seen most recently for your heart condition: ____________________

____

Date of last consultation ____________________

3 (a) Have you or have you been told you have angina pectoris (chest pain)? .... ☐ Yes ☐ No
(If "Yes," please provide details below.)

Date of Most Recent Symptoms	Name of Hospital	Name and Address of Doctor Consulted

(b) Have you been told you had a myocardial infarction (heart attack)? .... ☐ Yes ☐ No
(If "Yes," please provide details below.)

Date(s) of Heart Attack(s)	Name of Hospital	Name and Address of Doctor Consulted

4 How often do you have heart symptoms (chest, arm or neck discomfort, sense of chest pressure, etc.)?

Frequency ____________

5 (a) Date of MOST RECENT cardiac stress test ____________

(b) What were the results? ☐ Normal ☐ Abnormal

(c) What doctor or clinic has the results (if different than above)? ____________________

6 Have you had or been advised to have:

	Yes	No	Date	Name and Location of Hospital
Cardiac catheterization (coronary angiography)				
Coronary angioplasty (PTCA)				
Coronary artery bypass surgery				

7 How long were you out of work due to conditions in No. 3 and No. 6 above? ____________________

8 Are you taking any medications? .... ☐ Yes ☐ No
(If "Yes," please provide details below.)

Medication Name (Copy from Pharmacy label)	Date last taken	Dosage/Frequency

9 Do you carry nitroglycerin for chest discomfort? .... ☐ Yes ☐ No

If "Yes," date last used ____________

10 What are your average blood pressure readings ____________

11 Do you use tobacco in any form? ☐ Yes ☐ No

(a) If “Yes”:

(1) What type do you use? ______

(2) How often or many per day? ______

(b) If “No”:

(1) When did you stop? ______

12 Do you engage in regular exercise other than that occurreing during your work? ☐ Yes ☐ No

(If "Yes," please provide details below.)

(a)

Type of Exercise	Number of Times/Week	Number of Minutes Each Time

(b) How long have you been exercising as above? ______

(c) Is this part of a prescribed cardiac rehabilitation program? ☐ Yes ☐ No

14 Family History

(a) Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among your parents, brothers or sisters? ☐ Yes ☐ No

(b) Please provide details below:

	Age, if Living	Health	Age at Death	Cause of Death
Father				
Mother				
Brothers and Sisters				

15 What is your current height and weight? Height: ______ft. ______in. Weight: ______lbs.

Has there been any change in the last 12 months? ☐ Yes ☐ No

If "Yes," please provide details: ______

16 Do you have any other major medical impairments? ☐ Yes ☐ No

If "Yes," please provide details: ______

I hereby represent that all the statements and answers to the above questions are true and complete, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

______ Witnessed Signature of Proposed Insured ______ Date

______ Signature of Witness ______ Date