



## Coronary Artery Disease Questionnaire

**Agent:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Client:** \_\_\_\_\_ **DOB :** \_\_\_\_\_  *Male*  *Female*  
**Product/Face Amount:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

### **General Background/History:**

\* **TOBACCO/NICOTINE USE (past or present):**  **YES\*\*\***  **NO**

\*\*\*Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:

\* **FAMILY HISTORY:** (Family history may be a factor in determining rate class) **Is there a family history (parent or siblings) of the following conditions/disease onset prior to age 60:**

**Cardiac Disease**     **YES**  **NO**                      **Diabetes**                       **YES**  **NO**  
**Stroke or TIA**         **YES**  **NO**                      **Cancer**                       **YES**  **NO**

Please provide details for any "YES" response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (if living)	DECEASED (list age @ time of death)
<i>FATHER</i>				
<i>MOTHER</i>				
<i>SIBLING 1</i>				
<i>SIBLING 2</i>				

\* If proposed insured has undergone any form of stress testing, please provide the date(s)

*If performed, Was the stress EKG reported as ....*

*Normal*             *Abnormal*         *Borderline*     *Non-Diagnostic*

\* **Has the proposed insured undergone any other cardiovascular testing?** (If so please give details, type and report result, etc)

\* **Does the client have a history of any of the following?**

MI "Heart Attack" (s) \_\_\_\_\_ date(s) \_\_\_\_\_

Bypass surgery(\_\_\_\_\_ date(s) \_\_\_\_\_ # vessels \_\_\_\_\_

Angioplasty with stent? w/o stents (#) \_\_\_\_\_ w/o stents \_\_\_\_\_ date(s) \_\_\_\_\_ # vessels \_\_\_\_\_

\* **MEDICATIONS** - List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:

MEDICATION	DOSE	MEDICATION	DOSE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

\* Does the proposed insured require a specific diet? If yes, provide details:

\* Does the proposed insured engage in any regular exercise activities or any other risk factor modification?

\* Do you have any other significant health issues or medical conditions not outlined or mentioned on this form? (Complete additional questionnaires, as indicated)

Condition(s) - List treatment and current status:

NONE - NO other medical conditions or health issues.

### ***Cardiac Intervention – Specific Details (if applicable):***

\* Has the client undergone angioplasty with or without stent deployment? If yes, complete the following:

\* Provide date(s)/frequency of episode(s) and nature of symptoms that preceded the angioplasty.

\* Date of angioplasty

\* Was a stent or were multiple stents inserted? (list number, vessel(s) treated, etc.)

\* Did the client undergo any stress testing prior to the procedure? Results:

\* Has the client undergone any post-angioplasty stress testing? If so please list all details.

**\* Has the client undergone Bypass Surgery? If so, complete the following:**

**\* Date(s) frequency of episode(s) and nature of symptoms preceding the bypass surgery (CABG).**

**\* Date of Bypass Surgery:**

**\* How many bypass grafts were required? (*list number, vessel(s) treated, etc.*)**

**\* Did the client undergo any prior stress tests or any prior revascularization procedures? (*PTCA, CABG, Etc.*)**

**\* Has the client undergone any post-CABG stress testing? If so please list all details**

**\* Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.**

**\* Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?**

**\*\*\*\*If available please submit the actual results of all EKG's, stress tests, echocardiograms and/or cardiac catheterization results\*\*\*\*.**