

HEART DISEASE TREATMENT—ANGIOPLASTY QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of Birth: _____
 Face Amount: _____ Max. Premium: \$ _____/year UL WL Term Survivorship
 Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): Y N
 If Yes, please provide details: _____
 When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____
 Height: _____ ft. _____ in. Weight: _____ lbs.

(1) Provide date(s) or frequency of episode(s) of symptoms that have lead to the angioplasty:

- (a) Angina pectoris: _____
- (b) Coronary thrombosis/occlusion: _____
- (c) Coronary insufficiency: _____
- (d) Myocardial infraction (heart attack): _____

(2) Provide dates if any of the following tests or revascularization procedures have been done?

- Resting EKG: _____ Stress EKG: _____
- ThalliumStress EKG: _____ Echocardiogram: _____
- Coronary Catheterization: _____ Coronary Angioplasty: _____
- Percutaneous transluminal angioplasty (PTCA): _____ Directional Coronary Atherectomy: _____
- Rotational Atherectomy: _____ Coronary Artery Stents: _____
- Laser treatment: _____ Perfusion Balloon Catheter: _____
- Bypass Surgery: _____ Number of vessels involved: _____
- Other: _____

(3) Please check if the proposed insured as been diagnosed with the following conditions:

- Elevated Cholesterol - most recent known level: _____ High blood pressure - most recent reading: _____
- Diabetes - age of onset: _____ Recent A1C test result: _____ (also, please ask for our Diabetes Questionnaire)
- Family history of heart disease. If yes, who and at what age(s) diagnosed: _____
- Other: _____

(4) Does the proposed insured take any current medications, including preventative aspirin? No Yes Details:

(5) Does the proposed insured follow a specific diet (e.g. vegetarian) or take dietary supplements (vitamins, folic acid, etc.)?

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

- No Yes Details: _____

(6) Does the proposed insured engage in any regular exercise or sporting activity?

- No Yes Details: _____

(7) Are there any other conditions that may impact life underwriting? If yes, please describe: _____
