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# HEART DISEASE — ABNORMAL EKG 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. nicotine patch, cigars, pipe, snuff, 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) Which of the following tests have been done?** Please provide the date(s) for each:

- Resting EKG Date(s): \_\_\_\_\_  Stress EKG Date(s): \_\_\_\_\_
- Thallium Stress EKG Date(s): \_\_\_\_\_  Stress Echocardiogram Date(s): \_\_\_\_\_
- Coronary Catheterization Date(s): \_\_\_\_\_  Coronary Angiography Date(s): \_\_\_\_\_
- Other: \_\_\_\_\_

**(2) If a stress EKG was done, was it considered:**

- Normal  Borderline  Mildly Abnormal  Moderately abnormal  Strongly abnormal

**(3) Has the proposed insured had any of the following?**

- Chest pain (angina) - include dates: \_\_\_\_\_
- Heart attack - include date(s): \_\_\_\_\_
- Angioplasties - include date(s) and number of vessels involved: \_\_\_\_\_
- Bypass surgery date: \_\_\_\_\_ Vessel used for the graft: \_\_\_\_\_ No. of vessels involved: \_\_\_\_\_

**(4) Please advise if the proposed insured as been diagnosed with the following conditions:**

- Elevated Cholesterol - most recent known level(s): Total: \_\_\_\_\_ LDL: \_\_\_\_\_ HDL: \_\_\_\_\_ Triglycerides: \_\_\_\_\_
- Uncontrolled high blood pressure - most recent reading: \_\_\_\_\_
- Overweight - current height and weight: \_\_\_\_\_
- Diabetes - age of onset: \_\_\_\_\_ Recent A1C test result: \_\_\_\_\_ (also, please ask us for our Diabetes Questionnaire)
- Family history of heart disease. If yes, who and at what age(s) diagnosed: \_\_\_\_\_
- Other: \_\_\_\_\_

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

Name of medication (prescription or otherwise)	Dates used	Quantity taken	Frequency taken

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

\_\_\_\_\_

\_\_\_\_\_