



## 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. 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) 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: \_\_\_\_\_
- Thallium Stress 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:**

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

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

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: \_\_\_\_\_**

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