Return to - jim@uswolfe.com or Fax to 815-377-3556

Policy Number:_____ Date:____/____/_____

Chest Pain Questionnaire

Name:_____ Date of Birth:_____/_____/_____

Yes No Give details to all yes answers (dates, doctors names etc…)

1) Have you ever had:
   - A) Chest Pain? _____
   - B) Palpitation? Skipping Heart? _____
   - C) Shortness of breath? _____
   - D) High blood pressure? _____

2) If pain was experienced in the chest did it involve:
   - A) Middle of chest? _____
   - B) Left side of chest? _____
   - C) Left shoulder, arm or hand? _____
   - D) Both shoulders or arms? _____
   - E) Sense of pressure or constriction? _____
   - F) Sweating? _____
   - G) Was it associated with:
     - Exertion or Exercise? _____
     - Excitement or Strain? _____
   - H) Emergency medical care? _____

3) If any above answered yes please report:
   - A) Approximate date of first attack: _____
   - B) Date of last attack: _____
   - C) How frequent are attacks: Per day, week or month? _____
   - D) Duration of average attack: _____
   - E) Were you hospitalized? Yes No How long? _____
   - F) Were you confined at home? Yes No How long? _____
   - G) How long convalescent? _____
   - H) Date of return to work? Any restrictions? _____
   - I) How many hours do you work daily? _____
   - J) What medicine(s) are you taking now? _____

4) Please give names, addresses, and phone numbers of ALL your attending physicians.

5) What diagnosis was made concerning your heart?

Agent: _____

Agent Number: _____ Insured signature: _____

Agent signature: _____ Date signed: _____/_____/_____