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

CORONARY QUESTIONNAIRE

Insured's Name: DOB: State: Sex: M / F

Height: Ft. In. Weight: Face Amount:

Tobacco use in the past 5 years: No Yes Details:

Producer: State: Phone: E-mail:

Proposed Insured please answer the following:

1. Please circle any of the following you have had and give details:

Chest Pain or Angina	Date(s):	
Heart attack(s) (MI)	Date(s):	
Heart valve disease	Date(s):	
Abnormal heart rhythm or pulse	Date(s):	
Abnormal EKG (electrocardiogram)	Date(s):	
Heart murmur	Date(s):	
Bypass surgery(ies) (CABG)	Date(s):	How many vessels?
Angioplasty(ies) (PTCA)*	Date(s):	How many vessels?
Atherectomy(ies)*	Date(s):	How many vessels?

*If Stents were placed at the time of PTCA or Atherectomy, how many per date?

2. If surgery was done or is expected, for any of the above, please give details:

3. Do you have Atrial Fibrillation or Flutter (fast heartbeat)? Yes No

If so, is it Chronic (permanent) or Paroxysmal (intermittent)?

Please indicate the cause (please circle all that apply):

Alcohol	Cardiomyopathy	Coronary heart disease	Heart valve disease
Thyroid disease	Unknown	Other(s):	

Please indicate the symptoms (please circle all that apply):

Black-out Chest discomfort Dizziness (lightheadedness/faint feeling) Palpitations

What was used to get the heart back to the normal rhythm?

Date: Method used:

Date: Method used:

Date: Method used:

Date: Method used:

Do you have extra heart beats? Yes No
Details:

Do you have any other heart problems? Yes No
Details:

4. Have any of the following test(s) been completed (please circle all that apply)?

Thallium stress ECG	Date:	Results:
Stress echocardiograms	Date:	Results:
Coronary Angiography	Date:	Results:
Echocardiogram	Date:	Results:
Chest X-Ray	Date:	Results:
Other(s)	Date:	Results:

Details:

5. If you have had Angina, MI, PTCA, or CABG,
have you had a follow-up stress (exercise) EKG? Yes No
Details:

Date:

Results:

6. Have you had any chest discomfort since the MI, PTCA, or CABG? Yes No

7. Please list all medications that you are currently taking, and explain the reason for use:

8. Do you exercise on a regular basis? Yes No
Details:

9. Have you had any of the following (please circle all that apply)?
Cancer Diabetes Elevated cholesterol High Blood Pressure Overweight

10. Do you have a family history of heart disease (nearest relatives)?:

Relationship:	Age:	Living / Deceased ?
Relationship:	Age:	Living / Deceased ?
Relationship:	Age:	Living / Deceased ?
Relationship:	Age:	Living / Deceased ?

11. Name and address of your cardiologist and physician(s):

Additional Information:

Date: ______________ Insured's Signature: ________________________________