Client Name:		MEDICA	L HISTORY Q	UESTIC	ONNAIRE	: CORO	NARY /	ARTEF	RY DISEASE	
Gender:       Male       Female       Height:       Weight:       Weight:         Tobacou Usage:       Coverage Information:       UL       IUL       IUL         Promer       Date Stopped:       VIL       VIL       Survivorship         Current       Type:       WL       VIL       Survivorship         Face Amount:       Premium Tolerance:       VIL       Survivorship         Insurance Company       Face Amount       Year Issued       Replacement (Yes/No)         I. List the date(s) of diagnosis:	Client Name:				Date of Birth:					
Tobacco Usage:       Coverage Information:	Gender: Male	Female	Height:							
Former       Date Stopped:										
Current       Type:       Face Amount:         Preposed Insured's Existing Insurance         Insurance Company       Face Amount         Year Issued       Replacement (Yes/No)         Insurance Company Artery Disease:       Insurance         Sobes the client's family have a history of heart disease?       No         Yes       If Yes, date:       Insurance         Heart Attack:       No       Yes         Heart Attack:       No       Yes         Yes       If Yes, date:       If Yes, date:         Valve Surgery:       No       Yes         Abnormal lipid levels       Carotid Disease       High Bloo	Never		-	Гуре:	Term		UL		IUL	
Premium Tolerance:         Insurance Company       Face Amount       Year Issued       Replacement (Yes/No)         Insurance Company       Artery Disease:	Former Date S	topped:			WL WL		VUL		Survivorship	
Proposed Insured's Existing Insurance         Insurance Company       Face Amount       Year Issued       Replacement (Yes/No)         Insurance Company       Insurance Company       Insurance Company       Insurance Company         Insurance Company       Insurance Company       Insurance Company       Insurance Company         Insurance Company       Insurance Company       Insurance Company       Insurance Company       Insurance Company         Insurance Company       Insurance Company       Insurance Company       Insurance Company       Insurance Company       Insurance Company         Replacement (State       Insurance       Insurance Company       Insurance Company       Insurance Company       Insurance Company       Insurance Company       Insurance	Current Type:		F	Face Amo	ount:					
Insurance Company       Face Amount       Year Issued       Replacement (Yes/No)         I       Issued       Replacement (Yes/No)       Issued       Replacement (Yes/No)         1. List the date(s) of diagnosis:			F	Premium <sup>-</sup>	Tolerance:					
Insurance Company       Face Amount       Year Issued       Replacement (Yes/No)         I       Issued       Replacement (Yes/No)       Issued       Replacement (Yes/No)         1. List the date(s) of diagnosis:	Proposed Insured's Existing Insurance									
2. Type of Coronary Artery Disease:         3. Does the client's family have a history of heart disease?       No       Yes, list family members and details         4. Has the client had either of the following?       Bypass Surgery:       No       Yes       If Yes, date:         Goronary Angioplasty:       No       Yes       If Yes, date:						Replacement (Yes/No)				
2. Type of Coronary Artery Disease:         3. Does the client's family have a history of heart disease?       No       Yes, list family members and details         4. Has the client had either of the following?       Bypass Surgery:       No       Yes       If Yes, date:         Goronary Angioplasty:       No       Yes       If Yes, date:										
2. Type of Coronary Artery Disease:         3. Does the client's family have a history of heart disease?       No       Yes, list family members and details         4. Has the client had either of the following?       Bypass Surgery:       No       Yes       If Yes, date:         Goronary Angioplasty:       No       Yes       If Yes, date:										
2. Type of Coronary Artery Disease:         3. Does the client's family have a history of heart disease?       No       Yes, list family members and details         4. Has the client had either of the following?       Bypass Surgery:       No       Yes       If Yes, date:         Goronary Angioplasty:       No       Yes       If Yes, date:										
3. Does the client's family have a history of heart disease?       No       Yes, list family members and details         4. Has the client had either of the following?       Bypass Surgery:       No       Yes         Bypass Surgery:       No       Yes       If Yes, date:         Coronary Angioplasty:       No       Yes       If Yes, date:         Heart Attack:       No       Yes       If Yes, date:         Heart Attack:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         S. Has the client had any of the following?       Scarotid Disease       Cerebrovascular Disease         Diabetes       Elevated Homosyteine       High Blood Pressure         Diabetes       Elevated Homosyteine       High Blood Pressure         Irregular Heartbeat       Overweight       Peripheral Vascular Disease         6. Please list current medications:       Image: Stand Sta	1. List the date(s) of diagnosis:	:								
4. Has the client had either of the following?         Bypass Surgery:       No       Yes       If Yes, date:         Coronary Angioplasty:       No       Yes       If Yes, date:         Heart Attack:       No       Yes       If Yes, date:         Heart Failure:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         S. Has the client had any of the following?       Abnormal lipid levels       Carotid Disease       Cerebrovascular Disease         Diabetes       Elevated Homosyteine       High Blood Pressure         Irregular Heartbeat       Overweight       Peripheral Vascular Disease         6. Please list current medications:       Name of Medication       Dosage       Reason         7. Are there any other health issues? (Additional Questionnaires may be required)       No       Yes	2. Type of Coronary Artery Dise	ease:								
Bypass Surgery:       No       Yes       If Yes, date:         Coronary Angioplasty:       No       Yes       If Yes, date:         Heart Attack:       No       Yes       If Yes, date:         Heart Failure:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         S. Has the client had any of the following?       Carotid Disease       Cerebrovascular Disease         Diabetes       Carotid Disease       High Blood Pressure         Irregular Heartbeat       Overweight       Peripheral Vascular Disease         Name of Medication       Dosage       Reason         Name of Medications:       Image: Carotid Disease       No         Yes       Name of Medication       Dosage       Reason         Name of Medication       No       Yes       Yes         7. Are there any other health issues? (Additional Questionnaires may be required)       No       Yes	3. Does the client's family have	a history of hea	rt disease?		o 🗌	Yes, lis	t family m	nembers	and details	
Bypass Surgery:       No       Yes       If Yes, date:         Coronary Angioplasty:       No       Yes       If Yes, date:         Heart Attack:       No       Yes       If Yes, date:         Heart Failure:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         S. Has the client had any of the following?       Carotid Disease       Cerebrovascular Disease         Diabetes       Carotid Disease       High Blood Pressure         Irregular Heartbeat       Overweight       Peripheral Vascular Disease         Name of Medications:       Dosage       Reason         7. Are there any other health issues? (Additional Questionnaires may be required)       No       Yes										
Coronary Angioplasty:       No       Yes       If Yes, date:         Heart Attack:       No       Yes       If Yes, date:         Heart Failure:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         5. Has the client had any of the following?       Abnormal lipid levels       Carotid Disease       Cerebrovascular Disease         Diabetes       Elevated Homosyteine       High Blood Pressure         Irregular Heartbeat       Overweight       Peripheral Vascular Disease         6. Please list current medications:       Name of Medication       Dosage       Reason         7. Are there any other health issues? (Additional Questionnaires may be required)       No       Yes	4. Has the client had either of	the following?								
Heart Attack:       No       Yes       If Yes, date:         Heart Failure:       No       Yes       If Yes, date:         Valve Surgery:       No       Yes       If Yes, date:         5. Has the client had any of the following?       Abnormal lipid levels       Carotid Disease       Cerebrovascular Disease         Diabetes       Carotid Disease       High Blood Pressure         Diabetes       Overweight       Peripheral Vascular Disease         Irregular Heartbeat       Overweight       Peripheral Vascular Disease         Name of Medication       Dosage       Reason         Name of Medication       Image: Carotid Disease       No         7. Are there any other health issues? (Additional Questionnaires may be required)       No       Yes	Bypass Surgery:	🔲 No	🔲 Yes	If	Yes, date:					
Heart Failure: No   Valve Surgery: No   Yes If Yes, date:      5. Has the client had any of the following?   Abnormal lipid levels   Diabetes   Diabetes   Irregular Heartbeat   Overweight   Peripheral Vascular Disease   Name of Medications:      7. Are there any other health issues? (Additional Questionnaires may be required)	Coronary Angioplasty:	🔲 No	Yes	If	Yes, date:					
Valve Surgery: No Yes If Yes, date:   5. Has the client had any of the following?   Abnormal lipid levels Carotid Disease   Diabetes Elevated Homosyteine   Irregular Heartbeat Overweight   Peripheral Vascular Disease   6. Please list current medications:     Name of Medication   Dosage   Reason     7. Are there any other health issues? (Additional Questionnaires may be required)	Heart Attack:	🔲 No	🔲 Yes	If	Yes, date:					
5. Has the client had any of the following?	Heart Failure:	🔲 No	Yes	If	Yes, date:					
Abnormal lipid levels Carotid Disease Cerebrovascular Disease   Diabetes Elevated Homosyteine High Blood Pressure   Irregular Heartbeat Overweight Peripheral Vascular Disease   6. Please list current medications: Dosage Reason   Name of Medication Dosage Reason   Image: State of the state of th	Valve Surgery:	No No	Yes	If	Yes, date:					
Diabetes Elevated Homosyteine   Irregular Heartbeat Overweight   High Blood Pressure   Peripheral Vascular Disease     Ame of Medication     Dosage   Reason     Image: Comparison of Medication     Im	5. Has the client had any of th	e following?								
Irregular Heartbeat Overweight Peripheral Vascular Disease   6. Please list current medications: Dosage Reason     Name of Medication Dosage Reason     Image: Comparison of Medication Image: Comparison of Medication     7. Are there any other health issues? (Additional Questionnaires may be required) Image: Comparison of Medication	Abnormal lipid levels		Carotid Disease			Cerebrovascular Disease				
6. Please list current medications:         Name of Medication       Dosage         Reason         Image: Constraint of the second secon	Diabetes		Elevated Homosy	/teine		High Blood Pressure				
Name of Medication       Dosage       Reason         Image: Constraint of the state of	Irregular Heartbeat		Overweight			Periphe	ral Vascu	lar Dise	ase	
7. Are there any other health issues? (Additional Questionnaires may be required)     Image: No     Image: Yes	6. Please list current medicatio	ns:								
	Name of Medication		Dosage				Reason			
		sues? (Additiona	l Questionnaires r	nay be re	equired)			No	📙 Yes	
	ii yes, piease provide detalls:									

