

# Heart Disease Questionnaire

**Producer Name:** \_\_\_\_\_ **Contact Phone:** \_\_\_\_\_

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Client's Premium Tolerance (what do you need in order to place the case)? [required]

Any Tobacco/Nicotine Use in the Past 5yrs?  Yes  No If Yes, Type/Frequency/Date Last Used? \_\_\_\_\_

Face Amount: \_\_\_\_\_ Product: \_\_\_\_\_

Any Parent or Sibling Diagnosed with Cancer, Heart Disease, Stroke, Kidney Disease or Diabetes?  Yes  No

If Yes, Provide Age at Diagnosis, Age at Death, or Age if Still Living:

## If Your Client Has a History of Heart Disease, Please Answer the Following:

1. Has Client Had Any of the Following?

- |  |             |                           |                          |
|--|-------------|---------------------------|--------------------------|
| <input type="checkbox"/> Heart attack              | Date: _____ |                           |                          |
| <input type="checkbox"/> Catheterization/Angiogram | Date: _____ | Number of Blockages _____ | Percentage Blocked _____ |
| <input type="checkbox"/> Bypass Surgery            | Date: _____ | Number of Vessels _____   | Which Vessels? _____     |
| <input type="checkbox"/> Angioplasty (PTCA)/Stent  | Date: _____ | Number of Vessels _____   | Which Vessels? _____     |

If More Than One of Any of the Above Please Provide Additional Details and Dates:

2. Most Recent Blood Pressure Reading: \_\_\_\_\_

3. Most Recent Cholesterol: \_\_\_\_\_ HDL: \_\_\_\_\_ LDL: \_\_\_\_\_

3. Any Chest Pain, Discomfort or Any Complications Since the Heart Attack or Surgery was Completed?  Yes  No

4. Have Any of the Following Tests Been Completed Since the Heart Attack or Surgery in Order to Assess Current Heart Function?

- |  |             |                |
|--|-------------|----------------|
| <input type="checkbox"/> Resting EKG               | Date: _____ | Results: _____ |
| <input type="checkbox"/> Stress Test               | Date: _____ | Results: _____ |
| <input type="checkbox"/> Thallium Stress Test      | Date: _____ | Results: _____ |
| <input type="checkbox"/> Resting Echocardiogram    | Date: _____ | Results: _____ |
| <input type="checkbox"/> Stress Echocardiogram     | Date: _____ | Results: _____ |
| <input type="checkbox"/> Catheterization/Angiogram | Date: _____ | Results: _____ |
| <input type="checkbox"/> Ultrafast CT or EBCT      | Date: _____ | Results: _____ |

# Heart Disease Questionnaire

5. How Often Do You See Your Primary Care Physician for Follow Up? \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

6. How Often Do You See Your Cardiologist for Follow Up? \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

7. Please List All Prescription and Over the Counter Medications & Dosages Currently Being Taken:

Prescription, Over the Counter or Vitamins	Dosages	Reason

8. Does the Client Have Diabetes, Peripheral Vascular Disease, Cerebrovascular or Carotid Disease, or Any Other Known Medical Condition?  Yes  No If Yes, Please Provide Details:

9. Please Provide any Additional Information that Might be Useful, Including Details Regarding the Client's Current Diet and Exercise Routines, any Positive Health and Lifestyle Changes made Since the Diagnosis, Weight Loss, or Anything Else that Has Had a Positive Impact on the Client's Overall Health: