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?

☐ Heart attack	Date: _____		
☐ Catheterization/Angiogram	Date: _____	Number of Blockages _____	Percentage Blocked _____
☐ Bypass Surgery	Date: _____	Number of Vessels _____	Which Vessels? _____
☐ 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?

☐ Resting EKG	Date: _____	Results: _____
☐ Stress Test	Date: _____	Results: _____
☐ Thallium Stress Test	Date: _____	Results: _____
☐ Resting Echocardiogram	Date: _____	Results: _____
☐ Stress Echocardiogram	Date: _____	Results: _____
☐ Catheterization/Angiogram	Date: _____	Results: _____
☐ Ultrafast CT or EBCT	Date: _____	Results: _____

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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: