

MEDICAL HISTORY QUESTIONNAIRE: CORONARY ARTERY DISEASE

Client Name: _____

Date of Birth: _____

Gender: Male Female

Height: _____

Weight: _____

Tobacco Usage:

Coverage Information:

Never

Former

Current

Date Stopped: _____

Type: Term UL IUL

WL VUL

IUL

Survivorship

Type: _____

Face Amount: _____

Premium Tolerance: _____

Proposed Insured's Existing Insurance

Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. List the date(s) of diagnosis: _____

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:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Stent(s):	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Coronary Angioplasty:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Heart Attack:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Heart Failure:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Valve Surgery:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____

5. Has the client had any of the following?

<input type="checkbox"/> Abnormal lipid levels	<input type="checkbox"/> Carotid Disease	<input type="checkbox"/> Cerebrovascular Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Elevated Homosoteine	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Overweight	<input type="checkbox"/> 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

If yes, please provide details: _____
