Heart Disease Treatment-Coronary Angioplasty

Name: ______________________________ Date of Birth: ________________________

Height: _____________ Weight: _________ Sex: M/F

Tobacco Usage: ______________________ Face Amount: ______________________

___Term 10 15 20 30 ___UL

1. Provide date(s) or frequency of episode(s) of symptoms that have lead to the angioplasty:
(a) Angina pectoris: ____
(b) Coronary thrombosis/occlusion: ____
(c) Coronary insufficiency: ____
(d) Myocardial infraction (heart attack): ____

2. Provide dates if any of the following tests or revascularization procedures have been done?
___Resting EKG: ______________ ___Stress EKG: ______________
___Thallium Stress EKG: ____________ ___Echocardiogram: __________________
___Coronary Catheterization: _________ ___Coronary Angioplasty: _____________
___Rotational Atherectomy: _______________ ___Coronary Artery Stents: ________________
___Laser treatment: __________________ ___Perfusion Balloon Catheter: _____________
___Percutaneous transluminal angioplasty (PTCA): __________
___Directional Coronary Atherectomy: __________________
___Bypass Surgery: ______________ Number of vessels involved: _____________________________
___Other: ____

3. Please check if the proposed insured as been diagnosed with the following conditions:
___Elevated Cholesterol (recent known level): ___________
___High blood pressure (recent reading): ______________
___Diabetes - age of onset: ____ Recent A1C test result: ________ (Please ask for our Diabetes Questionnaire)
___Family history of heart disease (If so, whom and at what age(s) diagnosed): _________________
____
___Other: ____

4. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide the name, dosage, and frequency):
Name: ___________________ Dosage: _________________ Frequency: _______________
Name: ___________________ Dosage: _________________ Frequency: _______________

5. Does the proposed insured take any dietary supplements? ___Yes ___No
(If yes, please provide name, dosage, and frequency) ____
____

6. Does the proposed insured engage in any regular exercise? ___Yes ___No
(If yes, please describe): ____
____

(7) Are there any other conditions that may impact life underwriting? ___Yes ___No
(If yes, please describe): ____

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