Heart Bypass /Angioplasty/Stent Questionnaire

Name: ____________________________ Date of Birth: _________________________
Height: ____________ Weight: ________ Sex: M/ F
Tobacco Usage: ____________________ Face Amount: ______________________
___Term 10 15 20 30 ___UL

1. Did the proposed insured have the placement of stent(s), a bypass, or Angioplasty?
____

2. Did the proposed insured have a heart attack prior to the placement of stent(s), bypass or Angioplasty? ___Yes ___No
(If yes, please provide details):
____

3. Date of Surgery. ____

4. Please advise how many, and which, vessels were involved.
____

5. How badly was the vessels occluded (blocked) - percentage? _______________________________

6. Any restrictions of activities? ___Yes ___No
(If yes please provide details):
____

7. Are the postoperative EKGs normal? ___Yes ___No

8. When was the last treadmill EKG? ____

9. Did the proposed insured smoke prior to surgery? ___Yes ___No
(If yes, when did they quit)? __________________________________

10. Has the proposed insured been diagnosed with any of the following conditions?
___Coronary Artery Disease ___Abnormal heart rhythms/arrythmia ___Cardiomyopathy
___Heart Valve Disease ___Other: ____

11. Does the proposed insured have any family history of heart disease? ___Yes ___No
(If yes, please provide the relationship to the proposed insured and the date of onset and/or death):
____

12. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide name, dosage, and frequency):
____
____
____
____

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