

HEART DISEASE—HEART ATTACK QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$ _____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		
Height: _____ ft. _____ in. Weight: _____ lbs.		

(1) *Date(s) of heart attack(s):* _____

(2) *Has the proposed insured ever had any of the following?*

- | | |
|--|--|
| <input type="checkbox"/> Resting EKG Date(s): _____ | <input type="checkbox"/> Stress EKG Date(s): _____ |
| <input type="checkbox"/> Thallium EKG Date(s): _____ | <input type="checkbox"/> Echocardiogram Date(s): _____ |
| <input type="checkbox"/> Coronary Catheterization Date(s): _____ | <input type="checkbox"/> Coronary Angioplasty Date(s): _____ |
| <input type="checkbox"/> Heart Failure Date(s): _____ | <input type="checkbox"/> Arrhythmias Date(s): _____ |
| <input type="checkbox"/> Bypass Surgery Date(s): _____ | Number of vessels involved: _____ |

(3) *Please check if the proposed insured as been diagnosed with the following conditions:*

- Elevated Cholesterol - most recent known level: _____
- Uncontrolled high blood pressure - most recent reading: _____
- Overweight - current height and weight: _____
- Diabetes - age of onset: _____ Recent A1C test result: _____ (please ask us for our Diabetes Questionnaire)
- Family history of heart disease. If yes, who and at what age(s) diagnosed: _____
- Other: _____

(4) *Does the proposed insured take any current medications, including preventative aspirin?* No Yes Details: _____

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

(5) *Does the proposed insured take any dietary supplements (vitamins, minerals, folic acid, etc.)?*

- No Yes Details: _____

(6) *Does the proposed insured engage in any regular exercise?*

- No Yes Details: _____

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