

## MEDICAL HISTORY QUESTIONNAIRE: CORONARY ARTERY DISEASE

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Tobacco Usage:

Coverage Information:

Never  
 Former Date Stopped: \_\_\_\_\_  
 Current Type: \_\_\_\_\_

Type:  Term  UL  IUL  
 WL  VUL  Survivorship

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:	
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 Homosysteine	<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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_