

MEDICAL HISTORY QUESTIONNAIRE: CORONARY ARTERY DISEASE

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage: Never Former Current
 Date Stopped: _____ Type: _____

Coverage Information:
 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: _____
- _____
- _____
- _____