

## APPLICANT'S CHEST PAIN QUESTIONNAIRE

Supplement to application of \_\_\_\_\_ Date of Birth \_\_\_\_\_

<b>A. Have any of the following ever been experienced:</b> Yes No 1. Chest Pain? <input type="checkbox"/> <input type="checkbox"/> 2. Palpitation? <input type="checkbox"/> <input type="checkbox"/> 3. Shortness of Breath? <input type="checkbox"/> <input type="checkbox"/> 4. Other Chest Discomfort? <input type="checkbox"/> <input type="checkbox"/>	<b>B. Did Chest Pain involve:</b> Yes No 1. Middle of Chest? <input type="checkbox"/> <input type="checkbox"/> 2. Left side of Chest? <input type="checkbox"/> <input type="checkbox"/> 3. Left Shoulder, Arm or Hand? <input type="checkbox"/> <input type="checkbox"/> 4. Both Shoulders or Arms? <input type="checkbox"/> <input type="checkbox"/> 5. Sense of Pressure or Constriction? <input type="checkbox"/> <input type="checkbox"/>	<b>C. Was it associated with:</b> Yes No 1. Exertion? Exercise? <input type="checkbox"/> <input type="checkbox"/> 2. Excitement? Strain? <input type="checkbox"/> <input type="checkbox"/> 3. Meals? <input type="checkbox"/> <input type="checkbox"/>
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D. If any of above answered "Yes," complete the following questions:

1. Approximate date first chest pain? \_\_\_\_\_ Date of last chest pain? \_\_\_\_\_
2. How many attacks have you had? \_\_\_\_\_
3. How long were you disabled? \_\_\_\_\_
4. Hospitalized? How long? \_\_\_\_\_
5. Confined at home? How long? \_\_\_\_\_
6. Date of return to work? Any restrictions? \_\_\_\_\_
7. What was diagnosis given you by your doctor? \_\_\_\_\_
8. Name and address of doctor making diagnosis \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
9. Name and address of doctor you last consulted for this condition \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
10. a. How often do you report to him? \_\_\_\_\_ b. When did you last report to him? \_\_\_\_\_ c. Why? \_\_\_\_\_
11. a. When did you last have chest pain or discomfort? \_\_\_\_\_ b. Do you carry Nitroglycerin? \_\_\_\_\_ c. When did you last use this? \_\_\_\_\_
12. What other medicine are you now taking and why? \_\_\_\_\_
13. When was your last electrocardiogram taken? \_\_\_\_\_ By whom? \_\_\_\_\_

I agree that all statements and answers to questions above are complete and true to the best of my knowledge and belief.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Signature of Proposed Insured