

CORONARY ARTERY DISEASE QUESTIONNAIRE

Name of Proposed Insured _____	Date of Birth _____
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1. Name and address of cardiologist or other doctor seen most recently for your heart condition: _____

Date of last consultation: _____

2. Have you had or been told you have had:	Yes	No	Date of Most Recent Symptoms	Name of Hospital	Name & Address of Doctor Consulted
A. Angina Pectoris (heart pain)					
B. Myocardial Infarction (heart attack)					

3. How often do you get heart symptoms (chest, arm or neck discomfort, sense of chest pressure, etc)? No. of times per month _____ per year _____

4. A. Date of MOST RECENT treadmill (Stress) electrocardiogram: _____ B. What were you told about the results? Normal Abnormal
 C. What Doctor or Clinic has the results? _____

5. Have you had or been advised to have:	Yes	No	Date	Name and Location of Hospital
A. Cardiac Catheterization(CoronaryAngiography)				
B. Coronary Angioplasty (PTCA)				
C. Coronary Artery Bypass Surgery				

6. How long were you out of work due to conditions in No. 2 and No. 5 above? _____

7. List all medications currently prescribed: _____

8. Do you carry a pill to be placed under the tongue for chest discomfort? Yes No If "Yes," date last used _____

9. Date of last blood pressure check _____ Results _____

10. Date of last cholesterol check _____ Results _____

11. Do you use tobacco in any form? Yes No
 A. If "Yes,"
 1. What do you use? _____
 2. How often or many per day? _____
 B. If "No,"
 1. When did you stop? _____
 2. Did you stop on advice of a physician? Yes No
 If "Yes," explain and give name and address of physician: _____

12. Do you engage in regular exercise other than that occurring during your work:
 Yes No If "Yes":

A. Type of Exercise	No. of Times/Wk	No. of Minutes each time

B. How long have you been exercising as above? _____
 C. Is this part of a prescribed cardiac rehabilitation program? Yes No

13. Family History

A. Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among your parents, brothers or sisters? Yes No
 B. Give following information:

	Age, If Living	Health	Age At Death	Cause of Death
Father				
Mother				
Brothers & Sisters				

14. Diet Program

A. Do you check your weight periodically to detect any change? Yes No Your weight: _____ lbs. Height: _____
 B. Do you make any planned or supervised adjustments in your eating habits to maintain what you consider to be a desirable weight? Yes No
 C. Have you, within the past 3 years, followed a controlled diet? Yes No
 1. If "Yes," was it controlled with respect to: Total calories Cholesterol Fats Salt Other _____
 2. Was information obtained from: Nutritionist Dietician Physician Your reading Structured weight program

I represent that all statements and answers to the 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 _____

