

Cardiovascular Questionnaire

Name _____ Sex M F Date of Birth _____

Height _____ Weight _____ Smoker? Y N State _____

Coverage Desired? _____ Amount _____ Plan Desired? _____

Have you ever been Rated or Declined for insurance? If YES Complete details please

Have you ever been told that you had: Circle all that apply) HYPERTENSION HEART ATTACK
STROKE CHEST PAIN PALPITATION SHORTNESS OF BREATH CORONARY INSUFFICIENCY
ARRHYTHMIA CORONARY ANGIOPLASTY CORONARY BY-PASS HEART VALVE DISEASE

Date of onset of condition, duration, severity, location? _____

Was it associated with exercise, exertion, excitement, any other circumstance? _____

If more than one attack, give frequency, duration, and date of last attack _____

Has treatment been completed? If YES, When? _____

Have you had a Treadmill EKG or any type of Stress Test? If so, When? _____

Were the results normal? _____

Do you experience any Chest Pains now? Y N

What have been your recent Blood Pressure readings? _____

What has been your recent Cholesterol readings? _____

Do you have Diabetes? Y N When Diagnosed? _____

If YES, what medication are you taking? _____

Do you have any Family History of Heart Disease or Diabetes? _____

What Lifestyle Changes have you made to treat your illness? _____

Please list all medications being taken: _____

Do you have any other major health problems? (example: cancer, etc)?

Please also submit a copy of any recent Catheterizations or Stress Tests

Broker Submitting Questionnaire: _____

Address _____

Phone: _____ FAX: _____ E-mail: _____

Please send completed form:

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