Rapid Risk
CORONARY QUESTIONNAIRE
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(ALWAYS Submit Pages 1 and 2)

Proposed Insured's Name: DOB: Sex: ☐ M ☐ F

Tobacco Use: ☐ Yes ☐ No Amount: Height: Ft. In. Weight:

Broker's Name: Face Amount:

BGA: Phone: Fax:

Proposed Insured please answer the following:

1. Have you had any of the following?

☐ Chest pain or ☐ Angina Dates:

☐ Heart attack(s) (MI) Dates:

☐ Bypass surgery(ies) (CABG) Dates: How many vessels?

☐ Angioplasty(ies) (PTCA)* Dates: How many vessels?

☐ Atherectomy(ies)* Dates: How many vessels?

*If Stents were placed at the time of PTCA or Atherectomy: How many, per date?

☐ Heart valve disease

☐ Abnormal heart rhythm or pulse

☐ Abnormal EKG (electrocardiogram)

☐ Heart murmur

If surgery was done or is expected, for any of the above, please give details:

☐ Atrial fibrillation or flutter: (fast heartbeat) ☐ Chronic (permanent) OR ☐ Paroxysmal (intermittent

-Cause:
- ☐ Alcohol
- ☐ Unknown or other:
- ☐ Cardiomyopathy
- ☐ Coronary heart disease
- ☐ Heart valve disease
- ☐ Thyroid disease

-Symptoms:
- ☐ Chest discomfort
- ☐ Black-out
- ☐ Dizziness (lightheadedness)/ faint feeling
- ☐ Palpitations

-What was used to get the heart back to the normal rhythm?

Date: Method used:

Date: Method used:

Date: Method used:

Date: Method used:

☐ Extra heart beats: Details:

☐ Any other heart problems: Details

2. Please provide details for any checked box above:

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3. Have any of the following test(s) been completed?

☐ Thallium stress ECG	Date:	Results:
☐ Stress echocardiograms	Date:	Results:
☐ Coronary Angiography	Date:	Results:
☐ Echocardiogram	Date:	Results:
☐ Chest X-ray	Date:	Results:
☐ Others (Details below):	Date:	Results:

4. If you have had Angina, MI, PTCA or CABG, have you had a follow-up stress (exercise) EKG?
   - ☐ No
   - ☐ Yes, the results were normal. Date:
   - ☐ Yes, the results were abnormal. Date:

5. Have you had any chest discomfort since the MI, PTCA or CABG? ☐ No ☐ Yes, Details:

6. Please list any medications you are currently taking, and explain reason for use:

7. Do you exercise on a regular basis? ☐ No ☐ Yes, Details:

8. Have you had any of the following? (If yes, please complete any/all appropriate questionnaires.)
   ☐ Diabetes ☐ High blood pressure ☐ Elevated cholesterol ☐ Cancer ☐ Overweight
   ☐ Family history of heart disease (nearest relatives):

Relationship:	Age:	☐ Living /	☐ Deceased
Relationship:	Age:	☐ Living /	☐ Deceased
Relationship:	Age:	☐ Living /	☐ Deceased
Relationship:	Age:	☐ Living /	☐ Deceased

9. Name and address of your cardiologist and physician(s):

Underwriter's Notes:

Date: _____ Proposed Insured's Signature: _____