



# Rapid Risk

## CORONARY QUESTIONNAIRE

### PAGE 1

(ALWAYS Submit Pages 1 and 2)

Proposed Insured's Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> 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?

- |   |                                 |        |                   |
|---|---------------------------------|--------|-------------------|
| <input type="checkbox"/> Chest pain or              | <input type="checkbox"/> Angina | Dates: |                   |
| <input type="checkbox"/> Heart attack(s) (MI)       |                                 | Dates: |                   |
| <input type="checkbox"/> Bypass surgery(ies) (CABG) |                                 | Dates: | How many vessels? |
| <input type="checkbox"/> Angioplasty(ies) (PTCA)*   |                                 | Dates: | How many vessels? |
| <input type="checkbox"/> 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:

<input type="checkbox"/> Atrial fibrillation or flutter: (fast heartbeat)	<input type="checkbox"/> Chronic (permanent) OR	<input type="checkbox"/> Paroxysmal (intermittent)
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-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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### PAGE 2

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

- |  |       |          |
|--|-------|----------|
| <input type="checkbox"/> Thallium stress ECG     | Date: | Results: |
| <input type="checkbox"/> Stress echocardiograms  | Date: | Results: |
| <input type="checkbox"/> Coronary Angiography    | Date: | Results: |
| <input type="checkbox"/> Echocardiogram          | Date: | Results: |
| <input type="checkbox"/> Chest X-ray             | Date: | Results: |
| <input type="checkbox"/> 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: | <input type="checkbox"/> Living / | <input type="checkbox"/> Deceased |
| Relationship: | Age: | <input type="checkbox"/> Living / | <input type="checkbox"/> Deceased |
| Relationship: | Age: | <input type="checkbox"/> Living / | <input type="checkbox"/> Deceased |
| Relationship: | Age: | <input type="checkbox"/> Living / | <input type="checkbox"/> Deceased |

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

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Underwriter's Notes:

Date: \_\_\_\_\_ Proposed Insured's Signature: \_\_\_\_\_