

## HEART DISEASE—ABNORMAL EKG QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of Birth: \_\_\_\_\_  
 Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_/year  UL  WL  Term  Survivorship  
 Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_  
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):  Y  N  
 If Yes, please provide details: \_\_\_\_\_  
 When did you last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type used last: \_\_\_\_\_

**(1) Which of the following tests have been done? Please provide the date(s) for each:**

- Resting EKG Date(s): \_\_\_\_\_  Stress EKG Date(s): \_\_\_\_\_  
 Thallium Stress EKG Date(s): \_\_\_\_\_  Stress Echocardiogram Date(s): \_\_\_\_\_  
 Coronary Catheterization Date(s) \_\_\_\_\_  Coronary Angiography Date(s): \_\_\_\_\_  
 Other: \_\_\_\_\_

**(2) If a stress EKG was done, was it considered:**

- Normal  Borderline  Mildly Abnormal  Moderately abnormal  Strongly abnormal

**(3) Has the proposed insured had any of the following?**

- Chest pain (angina) - include dates: \_\_\_\_\_  
 Heart attack - include date(s): \_\_\_\_\_  
 Angioplasties - include date(s) and number of vessels involved: \_\_\_\_\_  
 Bypass surgery date: \_\_\_\_\_ Vessel used for the graft: \_\_\_\_\_ No. of vessels involved: \_\_\_\_\_

**(4) Please advise if the proposed insured as been diagnosed with the following conditions:**

- Elevated Cholesterol - most recent known level(s): Total: \_\_\_\_\_ LDL: \_\_\_\_\_ HDL: \_\_\_\_\_ Triglycerides: \_\_\_\_\_  
 Uncontrolled high blood pressure - most recent reading: \_\_\_\_\_  
 Overweight - current height and weight: \_\_\_\_\_  
 Diabetes - age of onset: \_\_\_\_\_ Recent A1C test result: \_\_\_\_\_ (also, please ask us for our Diabetes Questionnaire)  
 Family history of heart disease. If yes, who and at what age(s) diagnosed: \_\_\_\_\_  
 Other: \_\_\_\_\_

**(5) Does the proposed insured take any current medications, including preventative aspirin?  No  Yes Details:**

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

**(6) Are there any other conditions that may impact life underwriting? If yes, please describe:**

\_\_\_\_\_  
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