Heart Bypass / Angioplasty / Stent Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. Which of the following did the proposed insured have: ___ Stent(s) ___ Bypass ___ Angioplasty

2. Did the proposed insured have a heart attack prior to the above? ___ Yes ___ No
   If yes, provide details: _____

3. Date of surgery: _____

4. Which vessels were involved? _____
   _____

5. How badly were the vessels occluded (blocked)? _____ %

6. Any restrictions of activities? ___ Yes ___ No
   If yes, provide details: _____
   _____

7. Are the post-operative EKGs normal? ___ Yes ___ No

8. When was the last treadmill EKG? _____

9. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s): _____
   _____

10. Did the proposed insured smoke prior to surgery? ___ Yes ___ No
    If yes, when did they quit? _____

11. Does the proposed insured have any family history of heart disease? ___ Yes ___ No
    If yes, provide the relationship to the proposed insured and the date of onset and/or death: _____
    _____

12: Has the proposed insured been diagnosed with any of the following conditions:

___ Coronary Artery Disease ___ Abnormal heart rhythms/arrythmia
___ Cardiomyopathy ___ Heart Valve Disease
___ Other: _____

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