



# Appletree Financial Network 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:       Chronic (permanent)    OR     Paroxysmal (intermittent)  
(fast heartbeat)
- Cause:       Cardiomyopathy       Heart valve disease
- Alcohol       Coronary heart disease       Thyroid disease
- Unknown or other:
- Symptoms:       Black-out       Palpitations
- Chest discomfort       Dizziness (lightheadedness)/ faint feeling
- 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: | <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):

Underwriter's Notes:

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