



# Hypertension Questionnaire

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Producer \_\_\_\_\_ Phone \_\_\_\_\_

Client \_\_\_\_\_ Age/DOB \_\_\_\_\_ Gender \_\_\_\_\_

Desired Face Amount and coverage:	
Height and Weight:	
Date of or Age at Diagnosis:	
Most recent blood pressure reading (Systolic/Diastolic):	
Is hypertension currently under control?	
List any current medications, including dosage and frequency:	
Has the client made any lifestyle changes since diagnosis?	
Please check if the client has had any of the following:	<input type="checkbox"/> Chest pain or coronary artery disease <input type="checkbox"/> Family history of heart disease, high BP, stroke <input type="checkbox"/> Abnormal lipid levels <input type="checkbox"/> TIA or stroke <input type="checkbox"/> Enlarged heart <input type="checkbox"/> Aneurysm <input type="checkbox"/> Diabetes <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Kidney disease
Has the client smoked cigarettes in the past 12 months?	
Has a stress electrocardiogram (treadmill test) been completed within the past year?	<input type="checkbox"/> Yes, normal (provide date): _____ <input type="checkbox"/> Yes, abnormal (provide date): _____ <input type="checkbox"/> No
Has the client ever had an echocardiogram? If yes, provide date:	
Has the client ever had any other major medical conditions? Provide diagnosis date, treatment, results, etc.	

Please fax completed form to **949.455.0113** for your preliminary underwriting quote. Please remember that all quotes are tentative and are NOT BINDING and are SUBJECT TO full underwriting which may include exams, labs, doctor records, and/or any other information obtained during the underwriting process itself.