



Coronary Angioplasty Questionnaire

Name

DOB

Gender

Desired face amount and type of coverage:		
Height and Weight:		
Date of the procedure:		
How many blockages were opened? Where were they located?		
Has the client had any of the following? Check all that apply:	<input type="checkbox"/> Heart attack (date): _____ <input type="checkbox"/> Arrhythmia (frequency): _____ <input type="checkbox"/> Heart failure (date): _____ <input type="checkbox"/> Valve surgery (date): _____	
Has any follow-up testing been completed? Provide specifics:	<input type="checkbox"/> Yes—normal (type/date): _____ <input type="checkbox"/> Yes—abnormal (type/date): _____ <input type="checkbox"/> No	
Any chest pain or discomfort since the procedure?		
Has the client had any of the following? Check all that apply:	<input type="checkbox"/> Abnormal lipid levels <input type="checkbox"/> Diabetes <input type="checkbox"/> Overweight/obese <input type="checkbox"/> Elevated homocysteine <input type="checkbox"/> High blood pressure <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Cerebrovascular or carotid disease	
Medications being taken, including aspirin (provide dosage and frequency):		
Has the client smoked in the last 12 months?		
Has the client ever had any other major medical conditions? Provide diagnosis date, treatment, results, etc.		

Please return the completed form to your financial professional.

All quotes are tentative and are NOT BINDING and SUBJECT TO full underwriting which may include exams, labs, doctor records, and/or any other information obtained during the underwriting process.