Coronary Bypass Questionnaire

Name

DOB

Gender

Desired face amount and type of coverage:	
Height and Weight:	
Date of the bypass surgery:	
How many vessels were bypassed? Was there any mammary grafting?	
Has the client had any of the following? Check all that apply:	☐ Heart attack (date): ______ ☐ Coronary angioplasty (PTCA) (date): ______ ☐ Heart failure (date): ______ ☐ Valve surgery (date): ______
Has a follow-up stress (exercise) ECG been completed since the surgery?	☐ Yes—normal (date): ______ ☐ Yes—abnormal (date): ______ ☐ No
Any chest pain or discomfort since the surgery?	
Has the client had any of the following? Check all that apply:	☐ Abnormal lipid levels ☐ Overweight ☐ High blood pressure ☐ Irregular heart beat ☐ Diabetes ☐ Elevated homocysteine ☐ Peripheral vascular disease ☐ 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 you 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.