Coronary Bypass Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information

1	Date procedure was done:		Number of vessels by-passed			
2.	How badly were the vessels occluded (percentage?)					
3	Does client's family have any history of heart disease?	☐ Yes ☐ No	If yes provide details			
4	Has client had any of the following	Heart Attack	date	Heart Failure	date	
		Coronary Angioplasty (PTCA)		Valve Surgery		
5	List current medications (accurate name, dosage and reason)					
6.	Has a follow-up stress (exercise) EGG been completed since procedure	☐ Yes ☐ No	If yes, provide date and result	☐ Normal ☐ Abnormal		
7	Has the client had any chest discomfort since The Procedure	☐ Yes ☐ No	If yes, provide details			
8	Has the client had any of the following	Abnormal Lipid Levels		Diabetes		
		Overweight		Elevated Homocysteine		
		High Blood Pressure		Peripheral Vascular Disease		
		Irregular Heart Beats		Cerebrovascular Or Carotid Disease		