Hypertension 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 of first Diagnosis		What was the most recent blood pressure reading?	
2	Has client every had an echocardiogram	☐ Yes	☐ No	
3	List current medications (accurate name, dosage and reason)			
4	Please check any of the following that client has had	Chest pain Or coronary artery disease	Enlarged Heart	
		Diabetes	Aneurysm	
		Family history of Heart Disease, High Blood Pressure, Stroke	Peripheral Vascular Disease	
		Abnormal lipid levels	Kidney Disease	
		TIA or Stroke	Overweight	
5	Has a stress electrocardiogram (treadmill test) been completed within the past year?			
	☐ Yes normal, Date_____	☐ Yes abnormal, Date_____		
6	Does the client have any other health issues	☐ Yes ☐ No	If yes provide details:	