Heart Disease in Women 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(s) of the heart attack(s)**		
2	**Has your client had any of the following?**	☐ Echocardiogram *(date)*	☐ Bypass Surgery *(date)* _____ *# of vessels*_____
		☐ Coronary Catheterization *(date)*_____	☐ Heart Failure *(date)* _____
		☐ Coronary Angioplasty *(date)* *# of vessels* _____	☐ Arrhythmias *(date)* _____
3	**List current medications (accurate name, dosage and reason) – including aspirin.**		
4	**Has a follow-up stress (exercise) ECG been completed since the heart attack?**	☐ Yes, Normal *(date)*	
		☐ Yes, Abnormal *(date)*	
		☐ No	
5	**Has your client had any chest discomfort since the heart attack ?**	☐ Yes ☐ No	If yes provide details:
6	**The cause of the irregular heart beat is due to?**	☐ Abnormal Lipid Levels	☐ Diabetes
		☐ Overweight	☐ Elevated Homcysteine
		☐ High Blood Pressure	☐ Peripheral Vascular Disease
		☐ Irregular Heart Beats	☐ Cerebrovascular or Cartoid Disease
7	**Has your client smoked cigarettes in the last 12 months?**	☐ Yes ☐ No	
8	**Does the client have any other health issues?**	☐ Yes ☐ No	If yes provide details: