CPS INSURANCE SERVICES

CHEST PAIN QUESTIONNAIRE

Name_____ Date of birth_____

A. Have the following ever been experienced:	**Yes**	**No**	**B**. Did chest pain involve:	**Yes**	**No**	**C**. Was is associated with:	**Yes**	**No**
1. Chest pain?	☐	☐	1. Middle of chest	☐	☐	1. Exertion/Exercise?	☐	☐
2. Palpitations?	☐	☐	2. Left side of chest?	☐	☐	2. Excitement/Strain	☐	☐
3. Shortness of breath?	☐	☐	3. Left shoulder, arm, or hand?	☐	☐	3. Meal?	☐	☐
4. Other chest discomfort?	☐	☐	4. Both shoulders, or arms?	☐	☐			
			5. Sense of pressure or constriction?	☐	☐			

D. If any of above answered yes, complete the following questions:

1. Approximate date first chest pain_____ Date of last chest pain_____
2. How many attacks have you had?_____
3. How long were you disabled?_____
4. Hospitalized? How long? _____
5. Confined at home? How long? _____
6. Date of return to work. Any restrictions? _____
7. What was diagnosis given by your doctor?
   _____
8. Names and address of doctor making the diagnosis.
   _____
9. Name and address of doctor you last consulted for this condition:
   _____
10. a) How often do you report to him? b) When did you last report to him? c) Why?
    _____ _____ _____
11. a) When did you last have chest pain? b) Do you carry Nitroglycerin? c) When did you last use this?
    _____ _____ _____
12. What other medicine are you now taking, and why? _____
13. When was your last electrocardiogram taken? _____ By whom? _____

I represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief.

Signature of Proposed Insured_____ Date_____/_____/_____

Witness _____ Date_____/_____/_____

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