CPS INSURANCE SERVICES

CORONARY ARTERY DISEASE QUESTIONNAIRE

Name_____ Date of birth_____

1. Name and address of cardiologist or other physician seen most recently for your heart condition.

_____Date of last consultation_____/_____/_____

2. Have you had or been told you have had
   a. Angina pectoris (heart pain)
   b. Myocardial Infarction (heart attack)

Yes	No	Date	Name of Hospital	Name & Address of physician consulted

3. How often do you get heart symptoms (chest, arm, neck discomfort, or chest pressure, etc?) How many times: per month_____ per year_____

4. a. Date of MOST RECENT treadmill (stress) electrocardiogram: _____ b. What were the results ☐ Normal ☐ Abnormal
   c. What doctor or clinic has the results? _____

5. Have you had or ever been told you have:
   a. Cardiac Catheterization(Coronary Angiography)
   b. Coronary Angioplasty (PTCA)
   c. Coronary Artery Bypass Surgery

Yes	No	Date	Name & Location of Hospital

6. How long were you out of work due to conditions in question #2 and #5 above? _____

7. List all medications currently prescribed_____

8. Do you carry a pill to be placed under the tongue for chest pain? ☐ Yes ☐ No if "Yes", date last used _____/_____/_____

9. Date of last blood pressure check _____/_____/_____ results: _____

10. Date of last cholesterol check _____/_____/_____ results: _____

11. Do you use tobacco in any form? ☐ Yes ☐ No.
   a. If "Yes", What do you use? _____
   How often or many per day? _____

   b. If "No", When did you stop? _____
   Did you stop on the advise of a physician? ☐ Yes ☐ No
   If "Yes" explain and give names and addresses of physician:
   _____

   _____

12. Do you engage in regular exercise other than that occurring during work?
   ☐ Yes ☐ No If "Yes",

a. Type of Exercise	No. of times per /Wk	No. of minutes each time

   b. How long have you been exercising as above? _____

   c. Is this part of a prescribed cardiac rehabilitation program? ☐ Yes ☐ No

13. Family history
   a. Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among your parents, brothers, or sisters?
   ☐ Yes ☐ No
   b. Give the following information:

	Age. If Living	Health	Age at Death	Cause of Death
Father				
Mother				
Brothers & Sisters				

14. Diet Program:
   a. Do you check your weight periodically to detect any change? ☐ Yes ☐ No Weight: _____lbs Height: _____
   b. Do you make any planned or supervised adjustments in you eating habits to maintain what you consider to be a desirable weight? ☐ Yes ☐ No
   c. Have you, within the past 3 years, followed a controlled diet? ☐ Yes ☐ No
   If "Yes" was it controlled with respect to: ☐ Total calories ☐ Cholesterol ☐ Fats ☐ Salt ☐ Other _____
   Was information obtained from: ☐ Nutritionist ☐ Dietician ☐ Physician ☐ Your reading ☐ Structured weight program

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

Signature of Proposed Insured_____ Date_____/_____/_____

Witness_____ Date_____/_____/_____

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NATIONAL ASSOCIATION OF INDEPENDENT LIFE BROKERAGE AGENCIES