

HEART DISEASE QUESTIONNAIRE

Name of person completing questionnaire:		
Applicant's Name:		Date of Birth:
Social Security Number:	Height:	Weight:
Last Doctor's visit:	Any surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No	Chiropractor: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s):		Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Any auto/work related injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other medical conditions or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- Current height and weight: _____
- Have you been treated or hospitalized for a heart disorder or disease? Yes No
If yes, please list dates, diagnosis and explain treatment received. _____

- Have you ever had heart surgery? Yes No
If yes, please list type of surgery and dates. _____

- Have you ever had bypass surgery? Yes No
If so, how many arteries was it performed on? _____

- Of remaining arteries, what is percentage of blockage? _____

- Last three blood pressure readings and dates of those readings: _____

- Last three cholesterol readings and dates of those readings: _____

- Do you smoke? Yes No
If yes, how much? _____
- Do you have physical restrictions or limitations? Yes No
If yes, please explain. _____
- Are you currently taking ANY prescription medications? Yes No
If yes, please list ALL medications, their dosage and frequency. _____

- Do you have any other medical/health conditions? Yes No
If yes, please list. _____

To the best of my knowledge, all statements and answers on this questionnaire are complete and true. If any information should result as false or inaccurate, I understand my coverage will be terminated at any time.

Signature

Date