LARRY GORDON AGENCY, INC.

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Chicago - Milwaukee - Rockford

Cardiac Questionnaire

Broker Name: ______________________

1. Name of Proposed Insured: ______________________ Date of Birth: ______________
2. Height: ________ ft. ________ in. Weight: ________ lbs. Weight two years ago: ________ lbs.
3. Have you ever used tobacco? ☐Yes ☐No Date Last Used: ____________ Type: ______________
4. Name, address, and date of last consult of cardiologist or other doctor seen most recently for your heart condition:
____
5. a) Have you or have you been told you have angina pectoris (chest pain)? ☐Yes ☐No

Date of Most Recent Symptoms	Name of Hospital	Name and Address of Doctor Consulted

b) Have you been told you had a myocardial infarction (heart attack)? ☐Yes ☐No

Date(s) of Heart Attack(s)	Name of Hospital	Name and Address of Doctor Consulted

6. How often do you have heart symptoms (chest, arm or neck discomfort, sense of chest pressure, etc.)?
Frequency ____
7. a) Date of MOST RECENT cardiac stress test ____________ b) What were the results? ☐Normal ☐Abnormal
c) What doctor or clinic has the results (if different than above)? ______________________
8. Have you had or been advised to have:

	Yes	No	Date	Name and Location of Hospital
Cardiac catheterization (coronary angiography)				
Coronary angioplasty (PTCA)				
Coronary artery bypass surgery				

If "Yes," please provide which artery or vessel, location and extent of blockage? ______________________
9. How long were you out of work due to conditions in No. 5 and No. 8 above? ______________________
10. Are you taking any medication? ☐Yes ☐No

Medication Name (Copy from Pharmacy label)	Date Last Taken	Dosage/Frequency

11. Do you carry nitroglycerin for chest discomfort? ☐Yes ☐No If "Yes," date last used ______________
12. What are your average blood pressure readings ______________________________
13. a) Do you engage in regular exercise other than that occurring during your work? ☐Yes ☐No

Type of Exercise	Number of Times/Week	Number 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
14. Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among your parents, brothers or sisters? ☐Yes ☐No

	Age(s) if Living	Health	Age(s) at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

15. Do you have any other major medical impairments? ☐Yes ☐No **(If "Yes," please provide details on back.)**