Angina (Chest Pain)

Questionnaire

Knowledge. Experience. Results.

Please answer all questions applicable to the client's medical history.

Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____ ☐ Male ☐ Female

Face Amount _____ Max Premium $ _____ /yr. ☐ Term ☐ Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency _____ Date of last use _____ Type _____

If your client has had chest pain or angina, please answer the following:

Date of first occurrence _____

Is the client on any medications (including aspirin)

☐ Yes (details) _____

☐ No

Has the client had any of the following tests (check all that apply)

☐ Angiography
☐ MUGA Scan
☐ Resting EKG
☐ Stress Echocardiogram
☐ Stress EKG
☐ Thallium Stress EKG
☐ Ultrafast CT

Check if the client has had any of the following

☐ Abnormal Lipid Levels
☐ Diabetes
☐ Elevated Homocysteine
☐ Family History of Heart Disease
☐ High Blood Pressure

Provide the dates and details for the following (if applicable)

☐ Heart Attack(s) _____

☐ Bypass Surgery(s) _____

Number of Vessels _____

☐ Angioplasty(s) _____

Number of Vessels _____

List any other major health problems the client has:

Please submit the actual tracings and results of all stress electrocardiograms and any further testing if done (thallium, echo, or angiogram).

Questions? Call Jim or Teresa at 877.564.1707.
Please email the completed form to jrmosel@moseleymcgill.com.

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