

Policy Number: _____

Date: ____ / ____ / ____

Chest Pain Questionnaire

Name: _____

Date of Birth: ____ / ____ / ____

Yes No Give details to all yes answers (dates, doctors names etc...)

1) Have you ever had:

- A) Chest Pain? _____
- B) Palpitation? Skipping Heart? _____
- C) Shortness of breath? _____
- D) High blood pressure? _____

2) If pain was experienced in the chest did it involve:

- A) Middle of chest? _____
- B) Left side of chest? _____
- C) Left shoulder, arm or hand? _____
- D) Both shoulders or arms? _____
- E) Sense of pressure or constriction? _____
- F) Sweating? _____
- G) Was it associated with:
 - Exertion or Exercise? _____
 - Excitement or Strain? _____
- H) Emergency medical care? _____

3) If any above answered yes please report:

- A) Approximate date of first attack: _____
- B) Date of last attack: _____
- C) How frequent are attacks: Per day, week or month? _____
- D) Duration of average attack: _____
- E) Were you hospitalized? Yes No How long? _____
- F) Were you confined at home? Yes No How long? _____
- G) How long convalescent? _____
- H) Date of return to work? Any restrictions? _____
- I) How many hours do you work daily? _____
- J) What medicine(s) are you taking now? _____

4) Please give names, addresses, and phone numbers of ALL your attending physicians.

5) What diagnosis was made concerning your heart?

Agent: _____

Agent Number: _____

Insured signature: _____

Agent signature: _____

Date signed: ____ / ____ / ____