



CARDIAC QUESTIONNAIRE

Name (please print): _____ Date of Birth: _____ Policy #: _____ Date Completed: _____

Have you ever had:

- Chest pain?
- Angioplasty or balloon angioplasty?
- Palpitations?
- Stent placement?
- Fluttering or skipping of the heart?
- Heart Catheterization?
- Shortness of Breath?
- Heart studies due to symptoms or family history?
- Heart attack or heart failure?
- Coronary artery bypass graft (CABG)?

If you required bypass, angioplasty, or stenting please confirm the arteries involved.

When did the above event occur and was there only one event?

Please give the name and address of the physician you see for this condition.

When was the last time you saw your physician for this condition and how often do you see your physician for this condition?

Do you have any other significant medical history? (diabetes, emphysema, chronic obstructive pulmonary disease, stroke, cancer, carotid disease, kidney disease, vascular disease)*

Do you use tobacco in any form? (cigarettes, cigars, chew, nicotine gum)*

Are you currently on any medications? (accurate name, dosage and reason)*

(Accurate) Name of Medication:	Dosage:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any other major health issues? (heart disease, stroke, depression, ADHD)* Please give details: