

ANGIOPLASTY

CLIENT NAME:			Date:
☐ Male ☐ Female Date of birth: _			
Tobacco Use: Never used Totally stopped Date stopped: Use now Type of nicotine product:			
Type of Coverage: Term UL Survivor Type of Coverage: Term UL Survivor UL Coverage Amount: Anticipated Premium: Anticipated Premium:			
FAMILY HISTORY			
Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?			
If yes, use separate sheet to provide this information, including age of onset and date of death			
		S EXISTING INSURANCE	
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?
1. List the date(s) of the angioplasty (P	PTCA):		
2. How many vessels required the procedure?			
3. Why was an angioplasty done? (give specific details)			
4. Does client's family have any history of heart disease? 🗆 No 🖂 Yes			
5. Has client had either of the following? Heart attack (date), Bypass surgery			
(date)			
6. Has a follow-up stress (exercise) ECG been completed since procedure?			
□ Yes. normal (date) □ Yes. abnormal (date) □ No			
7. Has client had any chest discomfort since the procedure? \Box No \Box Yes; please give details			
7. Has cheft had any chest disconnect since the procedure? \Box No \Box Yes, please give details			
8. Has client had any of the following?			
🗆 abnormal lipid levels 🗆 diabetes 🗆 overweight 🗆 elevated homocysteine 🗆 high blood pressure 🗆 peripheral vascular disease			
🗆 irregular heart beats 🛛 cerebrovascular 🖾 carotid disease			
9. Please list current medications (including aspirin), (accurate name, dosage, and reason):			
(Accurate) Name of Medication	Dosage	Reason	
10. Are there any other health issues? (additional questionnaires may be required) 🗌 No 🗌 Yes; please give details			