



MEDICAL HISTORY QUESTIONNAIRE: ANGIOPLASTY

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage: Never Former Current
 Date Stopped: _____ Type: _____

Coverage Information: Type: Term WL UL VUL IUL Survivorship
 Face Amount: _____ Premium Tolerance: _____

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. List the date(s) of the angioplasty (PTCA): _____

2. How many vessels required intervention? _____

3. Why was the angioplasty done? (Please provide specific detail. Attach additional sheets as needed.)

4. Does client's family have any history of heart disease? No Yes

5. Has the client had either of the following?
 Heart Attack: No Yes If Yes, date: _____
 Bypass Surgery: No Yes If Yes, date: _____

6. Has a follow-up stress test been completed since recovery?
 No
 Yes, Normal Date: _____
 Yes, Abnormal Date: _____

7. Has the client had any chest discomfort since the procedure? No Yes
 If yes, please provide details: _____

8. Has the client had any of the following?
 Abnormal lipid levels Carotid Disease Cerebrovascular Disease
 Diabetes Elevated Homosysteine High Blood Pressure
 Irregular Heartbeat Overweight Peripheral Vascular Disease

9. Please list current medications (including aspirin):

Name of Medication	Dosage	Reason

10. Are there any other health issues? (Additional Questionnaires may be required) No Yes
 If yes, please provide details: _____