

## MEDICAL HISTORY QUESTIONNAIRE: ANGIOPLASTY

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Tobacco Usage:

Never  
 Former Date Stopped: \_\_\_\_\_  
 Current Type: \_\_\_\_\_

Coverage Information:

Type:  Term  UL  IUL  
 WL  VUL  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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_