Diversified Marketing Group, Inc.
CORONARY QUESTIONNAIRE

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(ALWAYS Submit Pages 1 and 2)

Proposed Insured's Name: DOB: Sex: ☐ M ☐ F

Tobacco Use: ☐ Yes ☐ No Amount: Height: Ft. In. Weight:

Broker's Name: Face Amount:

BGA: Phone: Fax:

Proposed Insured please answer the following:

1. Have you had any of the following?

☐ Chest pain or ☐ Angina Dates:

☐ Heart attack(s) (MI) Dates:

☐ Bypass surgery(ies) (CABG) Dates: How many vessels?

☐ Angioplasty(ies) (PTCA)* Dates: How many vessels?

☐ Atherectomy(ies)* Dates: How many vessels?

*If Stents were placed at the time of PTCA or Atherectomy: How many, per date?

☐ Heart valve disease

☐ Abnormal heart rhythm or pulse

☐ Abnormal EKG (electrocardiogram)

☐ Heart murmur

If surgery was done or is expected, for any of the above, please give details:

☐ Atrial fibrillation or flutter: (fast heartbeat) ☐ Chronic (permanent) OR ☐ Paroxysmal (intermittent)

-Cause:

☐ Alcohol ☐ Cardiomyopathy ☐ Heart valve disease

☐ Unknown or other: ☐ Coronary heart disease ☐ Thyroid disease

-Symptoms:

☐ Chest discomfort ☐ Black-out ☐ Palpitations

☐ Dizziness (lightheadedness)/ faint feeling

-What was used to get the heart back to the normal rhythm?

Date: Method used:

Date: Method used:

Date: Method used:

Date: Method used:

☐ Extra heart beats: Details:

☐ Any other heart problems: Details:

2. Please provide details for any checked box above:

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3. Have any of the following test(s) been completed?

	Test	Date	Results
☐	Thallium stress ECG	Date:	Results:
☐	Stress echocardiograms	Date:	Results:
☐	Coronary Angiography	Date:	Results:
☐	Echocardiogram	Date:	Results:
☐	Chest X-ray	Date:	Results:
☐	Others (Details below):	Date:	Results:

4. If you have had Angina, MI, PTCA or CABG, have you had a follow-up stress (exercise) EKG?
   - ☐ No
   - ☐ Yes, the results were normal. Date:
   - ☐ Yes, the results were abnormal. Date:

5. Have you had any chest discomfort since the MI, PTCA or CABG? ☐ No ☐ Yes, Details:

6. Please list any medications you are currently taking, and explain reason for use:

7. Do you exercise on a regular basis? ☐ No ☐ Yes, Details:

8. Have you had any of the following? (If yes, please complete any/all appropriate questionnaires.)
   ☐ Diabetes ☐ High blood pressure ☐ Elevated cholesterol ☐ Cancer ☐ Overweight
   ☐ Family history of heart disease (nearest relatives):

Relationship	Age	Living	Deceased
Relationship:	Age:	☐ Living /	☐ Deceased
Relationship:	Age:	☐ Living /	☐ Deceased
Relationship:	Age:	☐ Living /	☐ Deceased
Relationship:	Age:	☐ Living /	☐ Deceased

9. Name and address of your cardiologist and physician(s):

Underwriter's Notes:

Date: ____________ Proposed Insured's Signature: ______________________

FAX: 513-321-1360