

HEART DISEASE—HEART ATTACK QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of Birth: _____
 Face Amount: _____ Max. Premium: \$ _____/year UL WL Term Survivorship
 Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): Y N
 If Yes, please provide details: _____
 When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____
 Height: _____ ft. _____ in. Weight: _____ lbs.

(1) Date(s) of heart attack(s): _____

(2) Has the proposed insured ever had any of the following?

- | | |
|------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Resting EKG Date(s): _____ | <input type="checkbox"/> Stress EKG Date(s): _____ |
| <input type="checkbox"/> Thallium EKG Date(s): _____ | <input type="checkbox"/> Echocardiogram Date(s): _____ |
| <input type="checkbox"/> Coronary Catheterization Date(s): _____ | <input type="checkbox"/> Coronary Angioplasty Date(s): _____ |
| <input type="checkbox"/> Heart Failure Date(s): _____ | <input type="checkbox"/> Arrhythmias Date(s): _____ |
| <input type="checkbox"/> Bypass Surgery Date(s): _____ | Number of vessels involved: _____ |

(3) Please check if the proposed insured as been diagnosed with the following conditions:

- Elevated Cholesterol - most recent known level: _____
- Uncontrolled high blood pressure - most recent reading: _____
- Overweight - current height and weight: _____
- Diabetes - age of onset: _____ Recent A1C test result: _____ (please ask us for our Diabetes Questionnaire)
- Family history of heart disease. If yes, who and at what age(s) diagnosed: _____
- Other: _____

(4) Does the proposed insured take any current medications, including preventative aspirin? No Yes Details: _____

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

(5) Does the proposed insured take any dietary supplements (vitamins, minerals, folic acid, etc.)?

- No Yes Details: _____

(6) Does the proposed insured engage in any regular exercise?

- No Yes Details: _____

(7) Are there any other conditions that may impact life underwriting? If yes, please describe:

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