



# HEART ATTACK—MYOCARDIAL INFARCTION

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**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:** \_\_\_\_\_

### 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**

### PROPOSED INSURED'S EXISTING INSURANCE

Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. List date(s) of the heart attack(s): \_\_\_\_\_

2. Has the client had any of the following:

Echocardiogram Date: \_\_\_\_\_

Coronary catheterization Date: \_\_\_\_\_

Coronary angioplasty Date: \_\_\_\_\_

Bypass surgery Date: \_\_\_\_\_

Heart failure Date: \_\_\_\_\_

Arrhythmias Date: \_\_\_\_\_

3. Has a follow-up stress (exercise) ECG been completed since the heart attack?  No  Yes; please give details

4. Please check if your client has had any of the following:

Abnormal lipid levels  Irregular heartbeats\*  Peripheral vascular disease\*

Overweight  Diabetes; age of onset: \_\_\_\_\_  Cerebrovascular or carotid disease

High blood pressure  Elevated homocysteine

\*These conditions require an additional questionnaire to be completed, please request.

5. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. Does client have any other major health issues? (additional questionnaires may be required)  No  Yes; please give details