

# ANGIOPLASTY

**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 the date(s) of the angioplasty (PTCA): \_\_\_\_\_

2. How many vessels required the procedure? \_\_\_\_\_

3. Why was an angioplasty done? (give specific details)

\_\_\_\_\_

\_\_\_\_\_

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

5. Has client had either of the following?  Heart attack \_\_\_\_\_ (date),  Bypass surgery \_\_\_\_\_ (date)

6. Has a follow-up stress (exercise) ECG been completed since procedure?

Yes. normal \_\_\_\_\_ (date)  Yes. abnormal \_\_\_\_\_ (date)  No

7. Has client had any chest discomfort since the procedure?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

8. Has client had any of the following?

abnormal lipid levels  diabetes  overweight  elevated homocysteine  high blood pressure  peripheral vascular disease  
 irregular heart beats  cerebrovascular  carotid disease

9. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

10. Are there any other health issues? (additional questionnaires may be required)  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

