

Life Scan Questionnaire for **CORONARY BYPASS OR ANGIOPLASTY**
 LIFE INSURANCE RISK EVALUATION AND MARKET SEARCH

For _____ Male Female
 Date of Birth _____ Age _____ State _____
 Height _____ Weight _____ Non Smoker Smoker
 Have you ever used tobacco? Yes No If Yes, state month
 and year of last use of any tobacco product: _____
 Type of tobacco used Cigarettes Cigars Chews Pipe
 Amt \$ _____ Type Whole Life, Variable or Universal Term
 Last application for life insurance: Year _____ Company _____
 Result : Preferred Standard Rated/Rating _____ Declined
 Life Insurance Risk Evaluation and Market Search for Best Offer
 Risk Evaluation Only

Which of the following procedures was completed?

- Coronary Bypass
 Coronary Angioplasty (start at # symbol)

List Month and Year of Coronary Bypass or Angioplasty

Month _____ Year _____

Coronary Bypass, If a second bypass was performed, please indicate

Month _____ Year _____

How many grafts were performed?

- 1 2 3 4 5 6 or more

Indicate type of grafts used?

- Shaphenous vein (from legs) Internal mammary artery Both

Coronary Angioplasty, indicate when performed.

Month _____ Year _____ With stent? Yes No

If second angioplasty was performed, indicate when

Month _____ Year _____ With stent? Yes No

The procedure was performed on how many arteries?

- 1 2 3 4 5 6 or more

What condition preceded the Coronary Bypass or the Coronary Angioplasty?

Check all that apply

- Heart attack Chest pain Extreme fatigue
 Irregular stress EKG Other _____

Since the Coronary Bypass or Coronary Angioplasty, have you experienced any of the following:

- Chest pain Irregular stress EKG
 No problems since the surgery Other _____

Date last seen by a physician or medical practitioner?

Month _____ Year _____ Reason _____

Life Factors

Date of last stress EKG

Month ____ Year ____ Never

Family History, has either parent or any sibling died before age 65?

Yes No If yes, please list cause and age.

Blood Pressure, with or without medication _____ / _____

List medication, if any

Cholesterol _____

List all **other illnesses** not listed on this page.

List all medications currently being used.

(name, dosage and times per day)

Agent Information

Name _____

Address _____

City _____

ST ____ Zip ____ email _____

Phone _____

LIFE INSURANCE SOLUTIONS

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This is not an application for life insurance. The information contained herein will be used solely for the purpose of assessing which insurance carriers are likely to respond most favorably to the risk situation as stated above. The questions and answers listed will be used in the evaluation of the person listed above. All quotes are tentative, and are subject to the submitted medical evidence and other criteria used in the underwriting of life insurance.

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