CORONARY BYPASS

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 ☐ Disability **Coverage Amount:** ________________________

Annual Income:____________________ **Occupation/Job duties:** ______________________ **State of Residence:** __________________

Anticipated Premium: ________________________

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by 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?

Date of Bypass surgery: ______________________

3. Has client had any of the following?:

__heart attack ____________________ (date)
__coronary angioplasty (PTCA) (date)
heart failure (date)
__valve surgery (date)

4. Number of vessels by-passed?

5. How badly were the vessels occluded (percentage)?

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?

__yes; give details ______________________________________
no

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 or carotid disease

9. What medication is client on? (accurate name, dosage, and reason)

10. Are there any other health problems?

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