



HEART ATTACK (MYOCARDIAL INFARCTION) QUESTIONNAIRE
Global Insurance Resources Group Inc.
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CLIENT: NAME _____ [] M [] F, DATE OF BIRTH _____

AGE _____ HT _____ WT _____ STATE _____

AMOUNT REQ. \$ _____ MAX. ANNUAL PREMIUM \$ _____

TYPE OF INSURANCE: [] PERM [] TERM YRS. LEVEL _____

TOBACCO USE: [] NO [] YES, DETAIL _____

REPLACING? [] NO [] YES CURRENT ANN. PREM. \$ _____

LAST LIFE INSURANCE APP. YEAR: _____ COMPANY _____
 ACTION _____

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. LIST DATE (S) OF HEART ATTACK (S) AND SEVERITY OF EACH:

DATE _____
 [] MILD [] MODERATE [] SEVERE

HOW LONG UNTIL RETURN TO NORMAL ACTIVITIES?

DATE _____
 [] MILD [] MODERATE [] SEVERE

HOW LONG UNTIL RETURN TO NORMAL ACTIVITIES?

2. WHAT CONDITION (S) PRECEDED THE HEART ATTACK (S)?

- [] IRREGULAR STRESS EKG
- [] IRREGULAR EKG
- [] CHEST PAIN
- [] ARRHYTHMIA OR IRREGULAR HEART BEATS
- [] OTHER _____

3. ACTIVITIES CAPABLE OF PERFORMING (CHECKING LEVEL OF EXERCISE THAT BEST APPLIES):

- [] LEVEL ONE-HEAVY LABOR HANDBALL, CROSS COUNTRY, SKIING, RUNNING 10 MINUTE MILES, BICYCLING AT 12 MPH

5. CLIENT'S OCCUPATION _____

DO YOU WORK FULL TIME [] YES [] NO

6. SINCE THE HEART ATTACK, HAS THE CLIENT EXPERIENCED ANY OF THE FOLLOWING?

- [] CHEST PAINS OR ANGINA
- [] IRREGULAR EKG OR STRESS EKG
- [] ARRHYTHMIA
- [] CONGESTIVE HEART FAILURE

7. WHAT TESTS HAVE BEEN PERFORMED? (CHECK ALL THAT APPLY)

[] RESTING EKG, DATE _____

RESULTS _____

[] EXERCISE EKG, DATE _____

RESULTS _____

[] THALLIUM TEST, DATE _____

RESULTS _____

[] STRESS ECHO, DATE _____

RESULTS _____

LEVEL TWO- SHOVELING, WOOD CUTTING, CANOEING, JOGGING, 12 MINUTE MILES, SWIMMING CRAWL STROKE, ROWING MACHINE.

LEVEL THREE-CARPENTRY, LAWN MOWING, SINGLES TENNIS, DOWNHILL SKIING, SWIMMING BREAST STROKES

LEVEL FOUR- SEDENTARY LIFE STYLE (UNABLE TO DO ANY OF LEVELS ONE THROUGH TO THREE)

4. WHAT TREATMENT (S) HAVE BEEN PRESCRIBED?
DATE LAST CONSULTED PHYSICIAN: _____

LIST ALL MEDICATIONS:

SURGERY? IF YES, ANGIOPLASTY OR BYPASS:

_____ DATE

NUMBER OF ARTERIES OR GRAFTS PERFORMED ON:

_____ DATE

OTHER TREATMENTS: _____

CORONARY CATCH, DATE _____

RESULTS _____

8. LIST THE LAST CHOLESTEROL READING, IF KNOWN:

_____ HDL RATIO _____

9. LIST THE LAST BLOOD PRESSURE READING, IF KNOWN:

_____ SYSTOLIC _____ DIASTOLIC

10. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?

NO YES, PLEASE DETAIL

11. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?

NO YES, PLEASE DETAIL _____

12. PLEASE LIST ANY OTHER IMPAIRMENTS OR ILLNESSES OR ; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:

