SIMPLICITY ILLINOIS

# MEDICAL HISTORY QUESTIONNAIRE: ANGIOPLASTY

Client Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Tobacco Usage:

☐ Never
☐ Former Date Stopped: _____
☐ Current Type: _____

Coverage Information:

Type: ☐ Term ☐ UL ☐ IUL
☐ WL ☐ VUL ☐ Survivorship

Face Amount: _____

Premium Tolerance: _____

| Proposed Insured's Existing Insurance | | | |
|---|---|---|---|
| Insurance Company | Face Amount | Year Issued | Replacement (Yes/No) |
| | | | |
| | | | |
| | | | |

1. List the date(s) of the angioplasty (PTCA): _____
2. How many vessels required intervention? _____
3. Why was the angioplasty done? (Please provide specifc detail. Attach additional sheets as needed.)

_____

_____

_____

4. Does client's family have any history of heart disease? ☐ No ☐ Yes
5. Has the client had either of the following?
   - ☐ Heart Attack: ☐ No ☐ Yes If Yes, date: _____
   - ☐ Bypass Surgery: ☐ No ☐ Yes If Yes, date: _____
6. Has a follow-up stress test been completed since recovery?
   - ☐ No
   - ☐ Yes, Normal Date: _____
   - ☐ Yes, Abnormal Date: _____
7. Has the client had any chest discomfort since the procedure? ☐ No ☐ Yes

If yes, please provide details: _____

_____

_____

8. Has the client had any of the following?

| | | |
|---|---|---|
| ☐ Abnormal lipid levels | ☐ Carotid Disease | ☐ Cerebrovascular Disease |
| ☐ Diabetes | ☐ Elevated Homosyteine | ☐ High Blood Pressure |
| ☐ Irregular Heartbeat | ☐ Overweight | ☐ Peripheral Vascular Disease |

9. Please list current medications (including aspirin):

| Name of Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |

10. Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes

If yes, please provide details: _____

_____

_____

_____