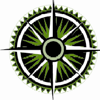

Oberlin Marketing
Supporting the direction of your business

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Life Insurance

Heart Questionnaire

Agent ____________________
Email ____________________
Phone ( ) ________-__________
Fax ( ) ________-__________

Client ____________________
❑ **Male** ❑ **Female** **DOB** __________
❑ **Non-Tobacco** ❑ **Tobacco**
❑ Never ❑ Cigarettes _____ per day
❑ Quit _______ ❑ Cigar _____ per week
❑ Pipe _____ per week
State __________ ❑ Chew _____ per week
Height __________
Weight __________ **U S Citizen** ❑ Yes ❑ No

Death Benefit $ ____________________
Plan ❑ Term 5 10 15 20 25 30
❑ Universal Life ❑ Option 1 ❑ Option 2
❑ Whole Life ❑ Par ❑ Non-Par
❑ 2nd to Die
❑ Simplified
❑ Guaranteed
Has client been ❑ Rated __________ ❑ Declined
Company ____________________

1 **Age at diagnosis** ____________________
2 **Was there a heart attack** ❑ Yes ❑ No
3 **Which conditions applied**
❑ Chest Pain ❑ Irregular EKG
❑ Shortness of Breath ❑ Fatigue
❑ Other ____________________
4 **Was there Coronary Bypass**
Date ____________________
How many vessels ____________________
Type of grafts used
❑ Saphenous vein (from legs)
❑ Internal Mammary Artery
5 **Was there Antioplasty**
Date ____________________
How many arteries ____________________
How many stents ____________________
6 **Was there a Pacemaker**
Date ____________________
Reason ____________________
7 **Any current symptoms**
❑ Chest Pain ❑ Irregular EKG
❑ Shortness of Breath ❑ Fatigue
❑ Other ____________________
8 **Last Doctor visit**
Date ____________________
9 **Last Stress EKG**
Date ____________________
10 **Type of exercise** ____________________
Frequency ____________________
11 **List any other illnesses or impairment in notes.**
Complete appropriate questionnaire if necessary.

Blood Pressure __________ **Cholesterol** __________
Current meds, dosage & reason
____
____
____
____
____

Do any of these activities apply?
❑ Aviation ❑ Racing
❑ Foreign Travel ❑ Scuba/Skin Diving
❑ Mountain Climbing ❑ Sky Diving
If yes, will need a questionnaire completed with details.

Moving Violations or DUI last 5 yrs
Date __________ Type __________
Date __________ Type __________
Date __________ Type __________

Family History - Cancer or Heart death or diagnosis in parents or siblings - who-what-when
____
____
____
____

Notes: ____________________
____
____
____
____
____
____