MADISON™ BROKERAGE
The Advisor's Advisor
ACRISURE® PARTNER

CARDIAC QUESTIONNAIRE

Name (please print): _____ Date of Birth: _____ Policy #: _____ Date Completed: _____

Have you ever had? **(Y or leave blank):**

- Chest pain? _____
- Palpitations? _____
- Fluttering or skipping of the heart? _____
- Shortness of Breath? _____
- Heart attack or heart failure? _____
- Coronary artery bypass graft (CABG)? _____
- Angioplasty or balloon angioplasty? _____
- Stent placement? _____
- Heart Catheterization? _____
- Heart studies due to symptoms or family history? _____

If you required bypass, angioplasty or stenting please confirm the arteries involved.

_____

When did the above event occur and was there only one event?

_____

Please give the name and address of the physician you see for this condition.

_____

When was the last time you saw your physician for this condition and how often do you see your physician for this condition?

_____

Do you have any other significant medical history? (diabetes, emphysema, chronic obstructive pulmonary disease, stroke, cancer, carotid disease, kidney disease, vascular disease)*

_____

Do you use tobacco in any form? (cigarettes, cigars, chew, nicotine gum)*

_____

Is the client on any medications now? (accurate name, dosage and reason)*

(Accurate) Name of Medication:	**Dosage:**	**Reason:**

Does client have any other major health issues? (cigarettes, cigars, chew, nicotine gum)* **If Y please give details:**

_____

_____

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