National Life Group®

National Life Insurance Company®
Life Insurance Company of the Southwest™

Cardiac Questionnaire

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

1. Have you ever had?

Chest pain?	☐ Yes ☐ No
Palpitations?	☐ Yes ☐ No
Fluttering or skipping of the heart?	☐ Yes ☐ No
Shortness of Breath?	☐ Yes ☐ No
Heart murmur?	☐ Yes ☐ No
Heart attack or heart failure?	☐ Yes ☐ No
Coronary artery bypass graft (CABG)?	☐ Yes ☐ No
Angioplasty or balloon angioplasty?	☐ Yes ☐ No
Stent placement?	☐ Yes ☐ No
Heart Catherization?	☐ Yes ☐ No
Heart studies due to symptoms or family history?	☐ Yes ☐ No

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

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

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

5. What type of tests are completed at your follow-ups and what were the results? *(EKG, stress test, echocardiogram, angiogram, holter monitor).*

6. What medications do you currently take for this condition?

7. Do you have any other significant medical history? *(diabetes, emphysema, chronic obstructive pulmonary disease, stroke, cancer, carotid disease, kidney disease, vascular disease)* * ☐ Yes ☐ No

8. Do you use tobacco in any form? *(cigarettes, cigars, chew, nicotine gum)** ☐ Yes ☐ No

**if question 7 or 8 is answered yes please contact your home office underwriter*

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