Producers Connection

Heart Risk Assessment

Please fax to 901-758-8841 or email to
ryan@pc4producers.com

Agent/agency requesting quote:_____

Applicant Name : _____

Date of birth: ___/___/___ **Ht/Wt**: ___'___" / _____ lbs. **Sex**: M F

Tobacco status: never used _____ Last Use: _____

currently use _____ type used _____ (how often _____)

Face amount(s) desired:$_____ $_____ $_____

Type of Product: Term UL WL

Regarding Client's
Symptoms:

Date of Onset:

Describe Symptoms:

When were last symptoms?
(chest pain, shortness of
breath, sweating?)

Risk Assessment– HEART

When did client last see Dr.?

How often does client see
Dr.?

Has Client Had Stress EKG? YES NO
Date & Results:

Was a Thallium or stress YES NO
echo test done?
Date & Results:

Was a cardiac catheterization YES NO
(or angiogram) done?

Date & Results:

Have you ever had a heart Attack? YES NO

If Yes, What arteries were involved?

Has the Client had a stent placed? If so, which vessels?

How much Blockage?

If Yes, what type of surgery
And when was it performed?

Results:

Family History of Heart Conditions:
(father, mother, siblings)

Ages at Onset:

Ages and Causes Death: