Heart Disease Screening Questionnaire

For Critical Illness Policies

Full Name:

Date of Birth:

Policy/Reference Number (if known):

Medical History

1. Have you ever been diagnosed with any heart or cardiovascular disease?

- Yes
- No

2. Do you currently experience chest pain, palpitations, or shortness of breath?

- Yes
- No

3. Have you ever undergone any heart-related procedures (e.g., angioplasty, bypass surgery, stenting)?

- Yes
- No

4. Do you have a family history of heart disease before age 60?

- Yes
- No

5. Are you currently taking any medications for high blood pressure, cholesterol, or heart disease?

- Yes
- No

6. Have you ever been advised to restrict physical activity due to a heart condition?

- Yes
- No

7. Please list any other relevant medical conditions or information:

Lifestyle

8. Do you smoke or have you smoked in the past 5 years?

- Yes
- No

9. How often do you exercise per week? (number of times)

Date:

Your Signature: