

Chest Pain Questionnaire

First name : _____ Last name : _____
 Policy number : _____ Date of Birth : _____

1. Have you ever experienced pain or discomfort in your chest? Yes No
 If yes, please provide details by answering the following questions:

2. Please indicate which of the following apply to your condition, and provide us with further details :

- | | | | | |
|--|---|--|--|---|
| Description of pain
<input type="checkbox"/> Sharp
<input type="checkbox"/> Stabbing
<input type="checkbox"/> Dull
<input type="checkbox"/> Aching
<input type="checkbox"/> Throbbing
<input type="checkbox"/> Heaviness
<input type="checkbox"/> Constriction
<input type="checkbox"/> Other : _____ | Location of pain
<input type="checkbox"/> Left side of chest
<input type="checkbox"/> Right side of chest
<input type="checkbox"/> Mid chest
<input type="checkbox"/> Shoulder(s)
<input type="checkbox"/> Back
<input type="checkbox"/> Jaw
<input type="checkbox"/> Other : _____ | Radiation of pain
<input type="checkbox"/> Left arm
<input type="checkbox"/> Right arm
<input type="checkbox"/> Both arms
<input type="checkbox"/> Back
<input type="checkbox"/> Jaw
<input type="checkbox"/> Other : _____ | Onset caused by
<input type="checkbox"/> Walking
<input type="checkbox"/> Lying down
<input type="checkbox"/> Eating
<input type="checkbox"/> Cold weather
<input type="checkbox"/> Exertion
<input type="checkbox"/> Other : _____ | Pain is relieved by
<input type="checkbox"/> Rest
<input type="checkbox"/> Sedatives
<input type="checkbox"/> Antacids
<input type="checkbox"/> Nitroglycerine
<input type="checkbox"/> Other : _____ |
|--|---|--|--|---|

- Test**
- None
 Electrocardiogram (ECG)
 Stress test
 Echocardiogram
 Angiogram
 Other: _____

Details (dates and results)

- Treatment / Surgery**
- None
 Medication
 Angioplasty
 Bypass surgery
 Other: _____

Details (dates, type and results)

3. Date you first experienced symptoms : _____
4. Frequency of symptoms : _____
5. Date of your last symptoms : _____
6. Was any hospitalization required for your chest pain? Yes No
 If yes, dates and duration: _____
7. Was any time required off work for your chest pain? Yes No
 If yes, dates and duration: _____
8. Do you have any pending consultation, treatment or surgery? Yes No
 If yes, please provide details (date, treatment, name of physician). _____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

Signature of the person to be insured (parent or legal guardian if a minor) _____ Date _____