



CHEST PAIN QUESTIONNAIRE

To be completed by the Life to be Insured

Name of the Life to be Insured

Policy No.

1. Have you ever had an attack of chest pain or discomfort? YES NO

If "YES", please state

a) site of pain or discomfort, i.e. whether in middle, left or right side of the chest, radiating to the left or right arm or elsewhere

b) Nature of pain or discomfort, i.e. vice-like, ache, burn, stabbing or knife-like

2. a) How frequently do these attacks occur? _____

b) What was the date of the first attack? _____

c) What was the date of the most recent attack? _____

3. a) What is the average duration? _____

b) If any attack lasted for more than 20 minutes, please state date (or dates) _____

4. Do attacks occur only on effort or exertion? YES NO

a) If "YES", must you stop the effort? _____

b) If attacks occur also at rest, at what time of the day do they take place? _____

5. Do you obtain relief from trinitrin or glycerin trinitrate tablets or isosorbide sublingual? YES NO

If "YES", how soon? _____

6. Have you been treated, or are you being treated with

a) trinitrin or glycerin trinitrate? YES NO

b) Herparin, Dicumarol, Dindevan, Tromexan, Hedulin or Coumadin YES NO

c) or any other anti-coagulant drug? YES NO

If "YES", state:

a) drug(s) and dosage _____

b) date and duration of treatment _____

7. How much activity are you allowed

a) at work?(if restricted, please say so and give date of resumption of full activity) :

b) at sport?

8. Has an electrocardiogram or an X-ray of your chest been taken?

YES

NO

If "YES", state date of most recent:

a) electrocardiogram

b) X-ray or chest

State name and address of medical attendant who has the results

9. Please state any further relevant particulars including name and address of personal medical attendant or attendants

I hereby declare that the above statements are full, complete and true and agree that this shall form part of my application for the Policy

Signature

Date

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