# CHEST PAIN QUESTIONNAIRE

(To be completed by the Applicant)

**Name, First name:** _____

**Date:** _____

This questionnaire will form part of the application.

If any questions below are answered "Yes", please supply full details below including dates and names of doctors and institutions where applicable.

1. Have you ever had chest pain or discomfort?

❑ No

❑ Yes – indicate the location and radiation of the pain on the diagram below. Use X to show the main area affected and an arrow (→) to show radiation, e.g. into jaw or arm.

a) Nature of pain or discomfort

❑ vice-like ❑ ache ❑ burning ❑ stabbing ❑ knife-like pain

❑ other _____

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

c) How frequently do these attacks occur? _____

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

2. What is the average duration of an attack? _____

a) Do attacks occur only on exertion?

❑ No

❑ Yes – must you stop the effort ❑ No ❑ Yes

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

c) Have you as far as you know received any of the following?

❑ Trinitrates (to place under the tongue)

❑ Treatment to cause thinning of the blood (e.g. warfarin, aspirin)

❑ Any other drugs for your heart?

❑ No ❑ Yes – please give details _____

d) Has any other medication ever been prescribed for your pain?

❑ No ❑ Yes – please state name of the drug and dosage _____

3. Has an electrocardiogram or a chest X-ray done in connection with the chest pain? ❑ Yes ❑ No

If "Yes", please state dates and results.

e) Electrocardiogram

❑ No ❑ Yes – please state dates and results _____

f) Chest X-ray

❑ No ❑ Yes – please state dates and results _____

4. Please state any further particulars which may be relevant including name and address of personal medical attendant(s)

_____

**I declare that the answers I have given are, to the best of my knowledge, true and I have not withheld any material information that may influence the assessment of acceptance of this proposal. I agree that this form will constitute part of my proposal for health insurance and that failure to disclose any material fact known to me may invalidate the contract.**

Signed: _____ Date (day/month/year): _____

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