

CHEST PAIN QUESTIONNAIRE

(To be completed by the Life to be Assured)

Full name of life to be assured

Application number

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1. Have you ever experienced a chest pain? ☐ Yes ☐ No

2. What was the date of the first attack of chest pain

3. How long did the pain last?

4. Have any attacks occurred subsequently? ☐ Yes ☐ No

If yes, please provide dates.

5. What was the nature and severity of the pain? e.g. very severe, crushing, vice-like, sharp, stabbing, dull ache, vague discomfort.

6. What was the location of the pain? e.g. central, in the left or right side of the chest, across the front of the chest, elsewhere in the chest.

7. Did the pain radiate outside the chest? e.g. to the shoulders, arms, jaw, abdomen.

8. What was the mode of onset? e.g. sudden, gradual, at rest, only on exertion ceasing with rest, only with certain postures, worsened by deep inspiration.

9. Were you given any treatment or undergo any investigations e.g. Stress Test? ☐ Yes ☐ No

If yes, please provide details including names of any medication.

10. Are you undergoing periodic preventive check-up for prevention of heart disease? ☐ Yes ☐ No

If yes, please provide all check-up reports.

11. Have your father, mother, brother, sister suffered from coronary artery disease? ☐ Yes ☐ No

If yes, please provide details like age, treatment details etc.

12. Have you been diagnosed as having

A. Hypertension (high blood pressure) ☐ Yes ☐ No

B. Diabetes ☐ Yes ☐ No

C. Ischemic / Coronary Heart Disease ☐ Yes ☐ No

D. Chronic Obstructive Lung Disease (COPD) ☐ Yes ☐ No

13. How many days you have been away from work due to chest pain?

14. Please provide any additional information on your condition, which will be helpful in processing your application.

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I hereby agree that the forgoing questions and answers shall form part of the proposal for insurance made by me to the Company.

Place: _____

Date: _____

Signature of the Life to be Assured / Proposer

Signature of the Medical Examiner / Code No.