Print Reset

CHEST PAIN QUESTIONNAIRE

NAME _____ **FILE** _____

1. Have you ever had any chest pain or discomfort? ❒ Yes ❒ No

   If **Yes**, where was location of chest pain? ❒ Center ❒ Side ❒ Over heart

   Did pain travel anywhere such as shoulder, arm, neck, jaw or back? ❒ Yes ❒ No

   If **Yes**, Where?_____

   How long did it last? _____

2. What were you doing when chest pain occurred?

   ❒ At rest ❒ Walking ❒ Doing heavy work or exercise ❒ Other

3. What gave you relief? _____

4. No. of episodes:_____

   Date of first episode:_____

   Date of last episode:_____

5. Please provide details of any tests or investigations that you have undergone for this: (e.g. blood test, coronary angiogram, echocardiogram, ECG, endoscopy, exercise stress test, etc.)

   Type of Test/ Dates/Results: _____

6. Please provide details of any medication taken for this condition:

   _____

7. Have you consulted a doctor because of chest pain? ❒ Yes ❒ No

   Hospitalized?_____

   When & Where?_____

   Cause and Diagnosis (e.g. angina, costochrondritis, esophageal reflux, muscle strain, myocardial infarction, palpitations, stress, etc.)_____

   Any follow up needed or further investigation?_____

   Do you have any associated symptoms/nausea/sweating/fatigue or required emergency consult?

   _____

8. Please give full name and address of **all** physicians consulted and dates last seen.

   _____

DECLARATION:
I declare that the answers and statements to the above questions are complete and true to the best of my knowledge and belief.
I understand they will form part of my application for insurance on my life.

I understand that if I do not fully, completely and truthfully answer the above questions (if I misrepresent my answers or statements) the Company may void this policy.

Date_____ Signature of Proposed Insured _____

PLEASE RETURN FORM TO:
The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, MB R3C 1A8
TOLL FREE: 1-888-997-9965 FAX: 1-888-985-3872 WEBSITE: wawanesalife.com