Blue text on a black background

Description automatically generated with medium confidence**CHEST PAIN QUESTIONNAIRE – APPLICANT**

(This questionnaire will form part of the application)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First Name:** |  | | **Last Name:** |  | |
| **Date of Birth** (mm/dd/yyyy): | |  | **Policy/Application No.** | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. When did you first experience chest pain? | | | | |  | | | | | | | |
| 1. How frequently do these attacks occur? | | | | | | | | | | | | |
| Frequency | | | | | Dates (Month/Year) | | | | | | | |
|  | | | | |  | | | | | | | |
| 3. What were you doing before the onset of the attack? | | | | | | | | | | | | |
| At rest  Exertion/Activity | | | | | | | | | | | | |
| 1. What is the average duration of an attack? | | | | | | Seconds | | | | Minutes | | Hours |
| 1. Where is the location and radiation of the pain? | | | | | | | | | | | | |
| Central part of the chest | | Right side of the chest | | | | | | | | Left side of the chest | | |
| Others: | | | | | | | | | | | | |
| 1. Describe the nature of pain or discomfort. | | | | | | | | | | | | |
| Stabbing | | Squeezing | | | | | | | | Chest Heaviness | | |
| Burning | | Constricting | | | | | | | | Others: | | |
| 1. Did the pain radiate to other parts of the body? | | | | | | | | | | | | |
| If **YES**, please check below:  No | | | | | | | | | | | | |
| Jaw | | | Neck | | | | | | Back | | | |
| Shoulder | | | Abdomen | | | | | | Others: | | | |
| 1. Was your chest pain triggered or aggravated by any of the following activities? | | | | | | | | | | | | |
| Exercise | | | | Yes  No | | | | | | | | |
| Body Movement/Exertion | | | | Yes  No | | | | | | | | |
| Breathing | | | | Yes  No | | | | | | | | |
| Others | | | | Yes  No | | | | | | | | |
| 1. Have you consulted a doctor for the chest pain? | | | | | | | Yes (Please provide details.)  No | | | | | |
|  | | | | | | | | | | | | |
| 1. Have you been admitted to a hospital/facility due to chest pain? | | | | | | | | Yes (Please provide details.)  No | | | | |
| Date Admitted  (Month/Year) | Date Discharged  (Month/Year) | | | | | Name of Hospital/Facility | | | | | Reason for Confinement | |
|  |  | | | | |  | | | | |  | |
|  |  | | | | |  | | | | |  | |
|  |  | | | | |  | | | | |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Did you undergo any test to investigate the cause of chest pain? | | | | | | | | Yes (Please provide details.)  No | | | |
| Date (Month/Year) | | Type of Diagnostic Test | | | | | | | Results | | |
|  | | ECG | | | | | | |  | | |
|  | | Chest X-ray | | | | | | |  | | |
|  | | Treadmill Stress Test | | | | | | |  | | |
|  | | Echocardiogram | | | | | | |  | | |
|  | | 24-Hour Holter Monitoring | | | | | | |  | | |
|  | | Thallium Perfusion Scan | | | | | | |  | | |
|  | | Blood Test: Creatine Phosphokinase | | | | | | |  | | |
|  | | Blood Test: Creatine Kinase (CK) | | | | | | |  | | |
|  | | Blood Test: Troponin | | | | | | |  | | |
|  | | Blood Test: CK-MB | | | | | | |  | | |
|  | | Blood Test: Myoglobin | | | | | | |  | | |
|  | | Others | | | | | | |  | | |
| 1. Were there medications prescribed for the chest pain? | | | | | | Yes (Please provide details.)  No | | | | | |
| Name of Medication | Date Prescribed (Month/Year) | | | Frequency and Dosage | | | Date Medication Stopped (Month/Year) | | | | Reason |
|  |  | | |  | | |  | | | |  |
|  |  | | |  | | |  | | | |  |
|  |  | | |  | | |  | | | |  |
| 1. Do you still experience chest pain? | | | | | Yes (Please provide details.)  No | | | | | | |
| When was the last time you had chest pain? | | | | | How long did your last chest pain last? | | | | | | |
|  | | | | |  | | | | | | |
| 1. Please provide any additional information that you feel is important. | | | | | | | | | | | |
|  | | | | | | | | | | | |
| 1. Please provide details regarding the doctors and/or specialists you see in relation to this condition: | | | | | | | | | | | |
| Name of Doctor, Hospital or Clinic | | | Address | | | | | | | Date of Last Consultation (Month/Year) | |
|  | | |  | | | | | | |  | |
|  | | |  | | | | | | |  | |

|  |
| --- |
| **DECLARATION** |
|  |
| **I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.**  **I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.** |

|  |  |
| --- | --- |
| **Name:** |  |

|  |  |
| --- | --- |
| **Signature:** |  |

|  |  |
| --- | --- |
| **Date of Signing:** |  |

A picture containing text, font, screenshot, black

Description automatically generatedA picture containing text, screenshot, black, font

Description automatically generated