



# INSURANCE DESIGNERS

Insurance Designers of Central Texas, LLC

## Pacemaker Questionnaire

12466 Los Indios Trail #100 Austin, TX 78729  
Phone 512-257-9700 FAX 512-257-9701

Today's Date: \_\_\_\_\_ Agent: \_\_\_\_\_  
 Full Name: \_\_\_\_\_ Male or Female? \_\_\_\_\_  
 Height and weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Month and year pacemaker implanted: \_\_\_\_\_

2. The pacemaker was implanted for:

- heart block associated with coronary artery disease
- complete heart block or sick sinus syndrome
- chronic underlying atrial flutter/fibrillation
- other; give details \_\_\_\_\_

3. Have any of the following pacemaker complications occurred? If so, when and what was the treatment?

- infection
- blood clots
- pacemaker malfunction
- perforation
- other; please give detail \_\_\_\_\_

4. Are there any continuing symptoms since the pacemaker was implanted?

- yes; give details \_\_\_\_\_
- no

5. When was your most recent cardiac workup and what test was it? *If you are able to get a copy of this test from your doctor, please fax it to us as it will help with getting a more solid tentative offer from the insurance company.*

- Nuclear stress test                      Date: \_\_\_\_\_
- Stress echocardiogram                      Date: \_\_\_\_\_
- Other \_\_\_\_\_

6. What medication do you take, reason, dosage and how often?

7. Has your weight remained stable in the past year?  Yes  No  
If no: Lost \_\_\_\_\_ pounds OR Gained \_\_\_\_\_ pounds

8. Please indicate type of tobacco EVER used:

| Type:                               | Amount per (circle frequency):                | Date last used: | Still use?   |
|-------------------------------------|---|-----------------|--|
| <input type="checkbox"/> Smokeless  | <input type="checkbox"/> daily/monthly/yearly | _____           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> per day/month/year   | _____           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Cigar      | <input type="checkbox"/> per day/month/year   | _____           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Patch/Gum  | <input type="checkbox"/> per day/month/year   | _____           | <input type="checkbox"/> Yes <input type="checkbox"/> No |

9. Do you have any family history of heart disease?  Yes  No  
If yes, list member, age diagnosed and current age or age deceased.

10. How often do you exercise and what type?

11. How often do you see your primary care physician?