AGC HEALTH PLAN
ILLINOIS • MISSOURI
EST. 1960
www.agchealthplan.com

Cardiac Questionnaire

Claims Administrator:
Consociate•Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: ____________________

Employee name: ____________________

Dependent name (if condition is for dependent) ____________________

Age: __________ Height: __________ Weight: __________

Smoker? Yes or No Cigarettes/tobacco use per day? ____________________

Length of time used: ____________________

If not currently using, how long ago did you quit? ____________________

1. Diagnosis of heart disorder? (i.e. MVP, murmur, heart attack, congenital abnormality, etc): ____________________
2. Any current symptoms? (i.e. chest pain, palpitations, shortness of breath, rapid pulse rate, etc): ____________________
3. When diagnosed? ____________________ Tests performed and results: ____________________
4. Treatment and date received. Include any hospitalizations/surgeries: ____________________
5. All medications prescribed:

Medication Name	Dosage	Frequency	Current?	When stopped
			Yes or No	
			Yes or No	
			Yes or No	
			Yes or No	

6. Any elevated cholesterol or triglycerides? Yes or No If yes, date of test and results, and current treatment or complete Cholesterol questionnaire: ____________________
7. Any future testing/surgery/treatment required or recommended? If so, please provide details: ____________________
8. Date last seen for cardiac evaluation? Results? ____________________
9. If you had Angioplasty and/or Bypass surgery, how many vessels were done? __________

Please be advised that you may be required to submit medical records.

Employee signature: ____________________ Date: __________