LIC
LIFE INSURANCE CORPORATION OF INDIA

CHEST PAIN QUESTIONNAIRE

(To be completed by Proposer's Medical Attendant)

Proposal No. _____ Office _____

Name of the Life to be Assured _____ Age _____Years

Date of Birth _____ Occupation _____

Residence _____

1.	Has this applicant ever had an attack of epigastric or chest pain, radiating to: Neck .... Left or right jaw .... Left or right shoulder .... Left or right arm .... Left or right little finger .... And if so, please state nature of pain or discomfort Compressive or constriction sensation .... Tightness or constriction under the sternum .... Vice-like ache .... Stabbing .... Burn	
2.	If these pains were of clearly non-cardiac origin (e.g. due to gastric or duodenal ulcer, diaphragmatic hernia, arthritis or cervical or thoracic spine, lung disease, pleurisy, neuralgia or neurocirculatory asthenia etc.) Please give diagnosis and details...	
3.	If the pains were of definite cardiac origin (a) due to coronary insufficiency (functional).... (b) due to myocardial infraction (thrombosis and / or disease of the coats of the coronary arteries e.g. due to arterosclerotic changes and /or atherosclerotic narrowing) please give diagnosis and details.	
4.	Please give date and duration of first attack	
5.	Please give date and duration of the following attacks, if any	
6.	Did these attacks occur: after exertion and /or excitement ..... after meals ..... during the night (give details)	
7.	Were these attacks accompanied by complications such as ..... Embolism auricular fibrillation ..... Venous thrombosis ..... Paroxysmal tachycardia ..... Auricular flutter	

Contd..2

8. If ECGs have been made and are available, please attach the original records and a copy of the ECG reports (All original records will be returned immediately after inspection).

9. If an X-ray or radioscopy of the chest has been made, please state date and result:

10. If the special examinations mentioned hereunder have been carried out, please give dates and results:

Date					
Sedimentation Rate of Erythrocytes					
Leucocytes					
Transaminase units in the Blood Serum					

11. If the patient was hospitalized or bed confined at home, please state when and how long, giving dates:

	Place	From	To
Hospitalized			
Convalescent			
Date of return to:	Restricted activity		
	Full activity with medical approval		

If returned to full activity with some special restrictions.
Please give details.

12. Therapy?

13. To the best of your knowledge is there any other impairment of the cardio-vascular system?

14. Prognosis?

Dated at _____ on the _____day of _____20 _____

_____

Signature of the Medical Attendant

Name and Address (In Block Letters)

Qualifications :

Code No