

HEART DISEASE—CONGESTIVE HEART FAILURE QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$ _____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		
Height: _____ ft. _____ in. Weight: _____ lbs.		

(1) Date of diagnosis: _____

(2) The condition has been diagnosed that has lead to the Congestive Heart Failure?

- | | |
|---|---|
| <input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> Heart valve disease |
| <input type="checkbox"/> Irregular heart beats | <input type="checkbox"/> Congenital heart valve abnormality |
| <input type="checkbox"/> Atrial fibrillations | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Ventricular fibrillations | <input type="checkbox"/> Myocarditis |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Peripheral edema |
| <input type="checkbox"/> Other: _____ | |

(3) Provide dates if any of the following tests or procedures have been done to evaluate the condition?

- | | |
|---|--|
| <input type="checkbox"/> Resting EKG: _____ | <input type="checkbox"/> Stress EKG: _____ |
| <input type="checkbox"/> Thallium Stress EKG: _____ | <input type="checkbox"/> Echocardiogram: _____ |
| <input type="checkbox"/> Holter Monitor: _____ | <input type="checkbox"/> Chest X-ray: _____ |
| <input type="checkbox"/> Other: _____ | |

(4) Please provide the Ejection Fraction (EF) of the most recent stress echocardiogram: _____%

(5) Is there any family history of heart disease or premature death due to heart disease?

	Age (if living)	History of heart disease?	Age at death:	Cause of death:
Mother		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sister(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Brother(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		

(6) Does the proposed insured take any current medications? No Yes Details:

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

(7) Are there any other conditions that may impact life underwriting? If yes, please describe: _____

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