

## HEART DISEASE—MITRAL VALVE STENOSIS QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of Birth: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_/year  UL  WL  Term  Survivorship

Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_

Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):  Y  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) *Have you been diagnosed or have you experienced any of the following:*

- Light headedness     Breathlessness     Blackouts     Mitral regurgitation     Caughing blood
- Rheumatoid arthritis     Syphilis     Ankylosig spondylitis     Marfan's syndrome     Edema
- Elevated Cholesterol - most recent known levels: Date: \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_ Triglycerides \_\_\_\_\_
- High blood pressure - most recent reading(s): \_\_\_\_\_
- Diabetes - age of onset: \_\_\_\_\_ Recent A1C test result: \_\_\_\_\_ (please ask us for our Diabetes Questionnaire)
- Family history of heart disease. If yes, who and at what age(s) diagnosed: \_\_\_\_\_
- Other: \_\_\_\_\_

(3) *Provide dates if any of the following tests or procedures (a) have been done or (b) have been recommended to be done?*

- Resting EKG: \_\_\_\_\_  Stress EKG: \_\_\_\_\_
- Thallium Stress EKG: \_\_\_\_\_  Echocardiogram: \_\_\_\_\_
- Coronary Catheterization: \_\_\_\_\_  Stress Echocardiogram: \_\_\_\_\_
- Valve replacement surgery - which valves? \_\_\_\_\_
- Angioplasty - what specific type? (e.g. balloon...) \_\_\_\_\_
- Bypass Surgery: \_\_\_\_\_ Number of vessels involved: \_\_\_\_\_
- Other: \_\_\_\_\_

(4) *Does the proposed insured take any current medications, including aspirin?*  No  Yes Details: \_\_\_\_\_

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

(5) *Does the proposed insured follow a specific diet (e.g. vegetarian) or take dietary supplements (vitamins, folic acid, etc.)?*

- No  Yes Details: \_\_\_\_\_

(6) *Does the proposed insured engage in any regular exercise or sporting activity?*

- No  Yes Details: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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