

HEART DISEASE—CONGESTIVE HEART FAILURE 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: _____

(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:* _____
