MEDICAL HISTORY QUESTIONNAIRE: ATRIAL FIBRILLATION

Client Name: _____ Date of Birth: _____

Gender: ☐Male ☐Female Height: _____ Weight: _____

Tobacco Usage:

☐Never

☐Former Date Stopped: _____

☐Current Type: _____

Coverage Information:

Type: ☐Term ☐UL ☐IUL

☐WL ☐Survivorship

Face Amount: _____

Premium Tolerance: _____

PROPOSED INSURED'S EXISTING INSURANCE

INSURANCE COMPANY	FACE AMOUNT	YEAR ISSUED	REPLACEMENT (YES/NO)

1. Date of First Diagnosis: _____

2. Is the atrial fibrillation/flutter: ☐Chronic (permanent) ☐Paroxysmal (intermittent)

3. Are there any symptoms with the irregular heartbeat?:

☐Blackout ☐Dizziness, light-headedness, feeling faint

☐Palpitations: ☐Chest discomfort

4. Have any of the following tests been done? If so, please provide date completed and results.

☐ECG: _____

☐Stress Test: _____

☐Echocardiogram: _____

☐Holter Monitor: _____

5. Please list current medications (including aspirin):

NAME OF MEDICATION	DOSAGE	REASON

6. The cause of the atrial fibrillation/flutter is due to:

☐Alcohol ☐Coronary Artery Disease ☐Cardiomyopathy

☐Mitral Valve Disease ☐Thyroid Disease ☐Unknown

☐Other, give details _____

7. Date of Last Episode: _____

8. How Many Episodes a Year? _____

9. Are there any other health issues? (Additional Questionnaires may be required) ☐Yes ☐No;

If yes, please provide details: _____

_____

_____

_____