

HEART DISEASE - CARDIOMYOPATHY 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: _____		

(1) **Date of diagnosis:** _____ Considered: Mild Moderate Severe

(2) **The condition has been diagnosed as:**

- | | |
|--|--|
| <input type="checkbox"/> Dilated cardiomyopathy Grade: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 | <input type="checkbox"/> Ischemic cardiomyopathy |
| <input type="checkbox"/> Hypertensive cardiomyopathy Grade: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 | <input type="checkbox"/> Cardiomyopathy due to valve disorder |
| <input type="checkbox"/> Hypertrophic cardiomyopathy | <input type="checkbox"/> Alcoholic cardiomyopathy When quit alcohol? _____ |
| <input type="checkbox"/> Congestive cardiomyopathy | <input type="checkbox"/> Peripartum cardiomyopathy When recovered? _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Restrictive or infiltrative cardiomyopathy |

(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"/> Any known abnormalities: _____ | |

(4) **Does Proposed Insured know their left ventricular ejection fraction?** _____ %

(5) **Does Proposed Insured know their left ventricular wall thickness (mm) from echo?** _____ mm

(6) **Any history of Atrial Fib?** Yes No **Any history of congestive heart failure?** Yes No

(7) **Average blood Pressure:** _____ **Any history of arrhythmia?** Yes No

(8) **Any family history of sudden cardiac death?** No Yes _____

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

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