Valvular Heart Disease Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information

1	Date Surgery was completed		What type of valve was used (if replaced)	☐ Prosthetic (mechanical) ☐ Tissue (porcine or pig)	
2	Please check the type of valve surgery	☐ Valve Replacement	☐ Commissurotomy	☐ Valvuloplasty	☐ Other
3	Please check the type(s) of valve disorder	☐ Aortic Stenosis	☐ Mitral Stenosis	☐ Mitral Insufficiency	
		☐ Aortic Insufficiency	☐ Mitral Valve Prolapse		
4	Have any of the following occurred? (check all that apply)	☐ Chest Pain	☐ Heart Failure	☐ Palpitations	
		☐ Dizziness/fainting	☐ Trouble Breathing		
5	Is there a history of any other disease in addition to the valve disorder?	☐ Yes ☐ No	*If yes, give details:*		
6	List current medications (accurate name, dosage and reason)				
7	Does the client have any other health issues	☐ Yes ☐ No	*If yes provide details:*		