Atrial Fibrillation 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	Type of Atrial Fibrillation	Chronic (permanent)	Date First Diagnosed
		Paroxysmal (intermittent)	
2	Are there other symptoms with the irregular heart beat? (check all that apply)	Black-out	Dizziness (lightheadedness) faint feeling
		Palpitations	Chest discomfort
3	Have any of the following test been done, If so please give date (check all that apply)	EKG	*date*
		Stress Test	*date*
		Echocardiogram	*date*
		Holter Monitor	*date*
4	List all medications (accurate name, dosage, and reason)		
6	The cause of Atrial Fibrillation/flutter is due to (check all that apply)	Coronary Heart disease	Alcohol
		Thyroid Disease	Unknown
		Mitral Valve Disease	Cardiomyopathy
		Other(give details)	
7	Does the client have any other Health Issues? If yes, provide details (additional questionnaires maybe required)	Yes	*Details:*
		No	

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