Congestive Heart Failure 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 of Diagnosis		What is the cause of CHF	
2	Has the client had surgical heart repair?	☐ Yes ☐ No	If yes:	type Date:
3.	Does client have a history of any of the following (check all that apply)		Hypertension	Chronic Obstructive Pulmonary Disease
			Coronary Artery Disease	Pacemaker
	If any of the above, please provide details			
4	Has an angiogram, echocardiogram, stress test or heart scan been done?	☐ Yes ☐ No	If yes give details (provide a copy if available)	
5	List current medications (accurate name, dosage and reason)			
6	Does the client have any other health issues	☐ Yes ☐ No	If yes provide details:	