

# Mitral Valve Disorder Questionnaire



Submit This Form with your application for better informed underwriting

## Client Information

<b>Client Name:</b>					
<b>DOB:</b>	<b>Gender</b>	<b>Height</b>	<b>Weight</b>	<b>Marital Status</b>	
<b>Occupation &amp; Length of Employment:</b>					
<b>Tobacco Use</b>	Never Used	Totally Stopped		Current User	
		<b>Date Stopped</b>		<b>Type Used</b>	
<b>Type of Coverage</b>	Term	UL	Survivor	<b>Amount \$</b>	

## Essential Information

1	How long has this abnormality been present?				
2	Please check the type of valve disorder present	Mitral Stenosis	Mitral regurgitation	Mitral valve prolapse	
3	Have any of the following occurred (check all that apply)	Chest Pain	Trouble Breathing	Heart Failure	
		Palpitations		Atrial Fibrillation / flutter	
4	Is there a history of any other heart disease in addition to the mitral valve disorder (problems with other valves, coronary artery disease etc?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give details		
5	Have any additional studies been completed (check all that apply and give date)	<input type="checkbox"/> Echocardiogram	date		
		<input type="checkbox"/> Cardiac Catheterization	date		
		<input type="checkbox"/> None			
6	List current medications (accurate name, dosage and reason)				
7	Does the client have any other health issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes provide details:		

**Confidential**

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