Athlete's Heart 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 first Diagnosis**			
2	**Have any of the following symptoms occurred?**	Chest Discomfort	☐ Yes	☐ No
		Fainting Spells or Dizziness	☐ Yes	☐ No
		Shortness of Breath	☐ Yes	☐ No
		Palpitations	☐ Yes	☐ No
3	**Have any Cardiac Studies been completed?**	**ECERCISE TREADMILL**	**RESTING or EXERCISE ECHOCARDIOGRAM**	
		☐ Yes Normal	☐ Yes Normal	
		☐ Yes Abnormal	☐ Yes Abnormal	
		☐ No	☐ No	
4	**Is there any history of any heart disease (problems with valves, coronary artery disease, cardiomyopathy, etc?)**	☐ Yes ☐ No	*If yes provide details:*	
5	**List current medications (accurate name, dosage and reason)**			
6	**Does the client have any other health issues**	☐ Yes ☐ No	*If yes provide details:*	

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