

## HEART DISEASE—CONGESTIVE HEART FAILURE QUESTIONNAIRE

Agent: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of Birth: \_\_\_\_\_  
 Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_ /year  UL  WL  Term  Survivorship  
 Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_  
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):  Y  N  
 If Yes, please provide details: \_\_\_\_\_  
 When did you last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type used last: \_\_\_\_\_

(1) *Date of diagnosis:* \_\_\_\_\_

(2) *The condition has been diagnosed that has lead to the Congestive Heart Failure?*

- |  |  |
|--|--|
| <input type="checkbox"/> High blood pressure/hypertension<br><input type="checkbox"/> Irregular heart beats<br><input type="checkbox"/> Atrial fibrillations<br><input type="checkbox"/> Ventricular fibrillations<br><input type="checkbox"/> Cardiomyopathy<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Heart valve disease<br><input type="checkbox"/> Congenital heart valve abnormality<br><input type="checkbox"/> Hyperthyroidism<br><input type="checkbox"/> Myocarditis<br><input type="checkbox"/> Peripheral edema |
|--|--|

(3) *Provide dates if any of the following tests or procedures have been done to evaluate the condition?*

- |   |  |
|---|--|
| <input type="checkbox"/> Resting EKG: _____         | <input type="checkbox"/> Stress EKG: _____     |
| <input type="checkbox"/> Thallium Stress EKG: _____ | <input type="checkbox"/> Echocardiogram: _____ |
| <input type="checkbox"/> Holter Monitor: _____      | <input type="checkbox"/> Chest X-ray: _____    |
| <input type="checkbox"/> Other: _____               |  |

(4) *Please provide the Ejection Fraction (EF) of the most recent stress echocardiogram: \_\_\_\_\_ %*

(5) *Is there any family history of heart disease or premature death due to heart disease?*

	Age (if living)	History of heart disease?	Age at death:	Cause of death:
Mother		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sister(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Brother(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		

(6) *Does the proposed insured take any current medications?*  No  Yes Details:

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

(7) *Are there any other conditions that may impact life underwriting? If yes, please describe:* \_\_\_\_\_  
 \_\_\_\_\_