

HEART DISEASE—AORTIC REGURGITATION QUESTIONNAIRE

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|--|--------------|------------|
| Agent: _____ | Phone: _____ | Fax: _____ |
| Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____ | | |
| Face Amount: _____ Max. Premium: \$ _____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship | | |
| Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____ | | |
| Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| If Yes, please provide details: _____ | | |
| When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____ | | |
| Height: _____ ft. _____ in. Weight: _____ lbs. | | |

(1) *Date of diagnosis:* _____

(2) *Have you been diagnosed or have you experienced any of the following:*

- Light headedness Breathlessness Blackouts Aortic stenosis Coughing up blood
- Rheumatoid arthritis Syphilis Ankylosig spondylitis Marfan's syndrome Edema
- Elevated Cholesterol - most recent known levels: Date: _____ LDL _____ HDL _____ Triglycerides _____
- High blood pressure - most recent reading(s): _____
- Diabetes - age of onset: _____ Recent A1C test result: _____ (also, please ask us for our Diabetes Questionnaire)
- Family history of heart disease. If yes, who and at what age(s) diagnosed: _____
- Other: _____

(3) *Provide dates if any of the following tests or procedures (a) have been done or (b) have been recommended to be done?*

- Resting EKG: _____ Stress EKG: _____
- Thallium Stress EKG: _____ Echocardiogram: _____
- Coronary Catheterization: _____ Stress Echocardiogram: _____
- Valve replacement surgery - which valves? _____
- Angioplasty - what specific type? (e.g. balloon...) _____
- Bypass Surgery: _____ Number of vessels involved: _____
- Other: _____

(4) *Does the proposed insured take any current medications, including aspirin?* No Yes Details: _____

| Name of Medication (Prescription or Otherwise) | Dates Used | Quantity Taken | Frequency Taken |
|--|------------|----------------|-----------------|
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(5) *Does the proposed insured follow a specific diet (e.g. vegetarian) or take dietary supplements (vitamins, folic acid, etc.)?*

- No Yes Details: _____

(6) *Does the proposed insured engage in any regular exercise or sporting activity?*

- No Yes Details: _____

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

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