

# MITRAL VALVE DISORDER

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

## FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
**If yes, use separate sheet to provide this information, including age of onset and date of death**

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. How long has this abnormality been present? \_\_\_\_\_

2. Please check the type(s) of valve disorder present:

Mitral stenosis  Mitral regurgitation  Mitral valve prolapse

3. Have any of the following occurred?

Chest pain  No  Yes

Trouble breathing  No  Yes

Heart failure  No  Yes

Palpitations  No  Yes

Atrial fibrillation/flutter  No  Yes

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.)?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

5. Have additional studies been completed? (check all that apply)

Echocardiogram Date: \_\_\_\_\_

Cardiac catheterization Date: \_\_\_\_\_

None

6. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details

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