

# MITRAL VALVE PROLAPSE

**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. Have any of the following symptoms occurred? (check all that apply)

- Fainting or dizziness  No  Yes  
 Palpitations  No  Yes  
 Shortness of breath  No  Yes  
 Chest pain  No  Yes

3. Is there a history of any other heart disease in addition to the mitral valve prolapse (problems with other valves, coronary artery disease, etc.)?

No  Yes; please submit a copy of the report

\_\_\_\_\_

\_\_\_\_\_

4. Has an echocardiogram (ultrasound of the heart) been done?  No  Yes; please submit a copy of the report

\_\_\_\_\_

\_\_\_\_\_

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

(Accurate) Name of Medication	Dosage	Reason

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

\_\_\_\_\_

\_\_\_\_\_

