

HEART DISEASE—CARDIOMYOPATHY 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: _____
 Height: ____ft. ____in. Weight: ____lbs.

(1) *Date of diagnosis:* _____

(2) *The condition has been diagnosed as:*

- | | |
|--|---|
| <input type="checkbox"/> Dilated cardiomyopathy
<input type="checkbox"/> Myocarditis
<input type="checkbox"/> Myocardial fibrosis
<input type="checkbox"/> Myocardial degeneration
<input type="checkbox"/> Congestive cardiomyopathy
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Hypertrophic cardiomyopathy
<input type="checkbox"/> Idiopathic hypertrophic subaortic stenosis
<input type="checkbox"/> Alcoholic cardiomyopathy
<input type="checkbox"/> Peripartum cardiomyopathy
<input type="checkbox"/> Restrictive cardiomyopathy |
|--|---|

(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) *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		

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

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