# 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 ☐ Disability **Coverage Amount:** _____

**Annual Income:** _____ **Occupation/Job duties:** _____ **State of Residence:** _____

**Anticipated Premium:** _____

## FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by 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

_____

_____

 