VALVULAR HEART SURGERY

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. When was the surgery completed? _____

2. Please note type of valve surgery:
☐ Valve replacement   ☐ Valvuloplasty
☐ Commissurotomy   ☐ Other _____

3. Please check the type (s) of valve disorder:
☐ Aortic stenosis ☐ Mitral stenosis ☐ Mitral valve prolapse
☐ Aortic insufficiency   ☐ Mitral insufficiency

4. Please note type of valve used if replaced:

☐ Prosthetic (mechanical)   ☐ Tissue (porcine or pig)

5. Have any of the following occurred?

☐ Chest pain   ☐ Heart failure   ☐ Palpitations   ☐ Dizziness/fainting   ☐ Trouble breathing

6. Is there a history of any other disease in addition to the valve disorder (coronary artery disease, etc.)?   ☐ No   ☐ Yes; please give details

_____
_____

7. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____
_____