MEDICAL HISTORY QUESTIONNAIRE: ATRIAL FIBRILLATION

Client Name: ______________________ Date: ____________

Gender: ☐ Male ☐ Female Height: ____________ Weight: ____________

Tobacco Usage:

☐ Never

☐ Former Date Stopped: ____________

☐ Current Type: ____________

Coverage Information:

Type: ☐ Term ☐ UL ☐ IUL

☐ WL ☐ VUL ☐ Survivorship

Face Amount: ____________

Premium Tolerance: ____________

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of First Diagnosis: ____________
2. Is the atrial fibrillation/flutter: ____________
3. Are there any symptoms with the irregular heartbeat?

☐ Blackout ☐ Dizziness, light-headedness, feeling faint

☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? If so, please provide date completed and results.

☐ ECG: ____________

☐ Stress Test: ____________

☐ Echocardiogram: ____________

☐ Holter Monitor: ____________

5. Please list current medications (including aspirin):

Name of Medication	Dosage	Reason

6. The cause of the atrial fibrillation/flutter is due to:

☐ Alcohol ☐ Coronary Artery Disease ☐ Cardiomyopathy

☐ Mitral Valve Disease ☐ Thyroid Disease ☐ Unknown

☐ Other, give details ____________

7. Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes

If yes, please provide details: ____________