Atrial Fibrillation Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/ F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 __UL

1. When was the proposed insured diagnosed with Atrial Fibrillation? _____

2. Has the proposed insured been diagnosed with ___Chronic or ___Paroxysmal Atrial Fibrillation?

3. What is the underlying cause of the Atrial Fibrillation? (Check those that apply)

___High blood pressure	___Coronary artery disease	___ Cardiomyopathy
___Heart valve disease	___Having undergoing heart surgery	___Chronic lung disease
___Heart failure	___Congenital heart disease	___Pulmonary embolism
___Hyperthyroidism	___Pericarditis	___Viral infection

4. Has the proposed insured had any of the following symptoms?

___Chest discomfort	Date: _____	or ___	Currently experiences
___Black-out	Date: _____	or ___	Currently experiences
___Palpitations	Date: _____	or ___	Currently experiences
___Dizziness/faint feeling	Date: _____	or ___	Currently experiences

5. Has the proposed insured ever had any of the following procedures:

___Electrical Cardioversion	Date: _____
___Ablation	Date: _____
___Pulmonary vein antrum isolation:	Date: _____
___Implantation of a defribullator or pacemaker:	Date:_____

6. Is the proposed insured taking any medication?

Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____

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