Bicuspid Aortic Valve 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? _____

2. Does the proposed insured experience any of the following: (check all that apply)
   ___ chest pain ___ fatigue
   ___ shortness of breath ___ dizziness
   ___ fainting

3. How is the proposed insured being treated for this condition:
   ___ Surgical repair of the aortic valve Date: _____ Details: _____
   ___ Valve replacement Date: _____ Details: _____
   ___ Balloon valvotomy Date: _____ Details: _____
   ___ Other Date: _____ Details: _____

4. Has the proposed insured been diagnosed with endocarditis? ___Yes ___No
   (If yes, please provide details and date of diagnosis): _____
   _____
   _____

5. Is the proposed insured taking any medication for this condition or any other? ___ Yes ___ No
   (If yes, please provide the name, dosage, and frequency): _____
_____
_____

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