



Cardiomyopathy 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. The condition has been diagnosed as:

___ Dilated cardiomyopathy ___ Hypertrophic cardiomyopathy ___ Restrictive cardiomyopathy

___ Other: _____

3. Does the proposed insured suffer from any of the following symptoms? (Check all that apply)

___ Chest pain or pressure ___shortness of breath ___fatigue
___Swelling of lower extremities ___weight gain ___fainting
___Palpitations ___dizziness

4. Has the proposed insured undergone any of the following procedures?

___Pacemaker Date: _____
___Implantable cardioverter defibrillator Date: _____
___Other _____ Date: _____

5. Is there a family history of heart disease? ___Yes ___No

(If yes, please provide relationship to proposed insured and date of onset and/or death): _____

6. Is the proposed insured taking any medication? ___Yes ___No

(If yes, please provide name, dosage, and frequency): _____

