AORTIC VALVE DISORDER

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/ F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 __UL

1. Date of diagnosis: _____

2. Have you been diagnosed or have you experienced any of the following:

___ Light headedness ___ Breathlessness ___ Blackouts
___ Aortic stenosis ___ Coughing up blood ___ Rheumatoid arthritis
___ Syphilis ___ Ankylosig spondylitis ___ Marfan's syndrome
___ Edema
___ Elevated Cholesterol - most recent known levels: Date: _____
LDL _____ HDL _____ Triglycerides _____
___ High blood pressure - most recent reading(s): _____
___Diabetes - age of onset: _____ Recent A1C test result: _____
(Also, please ask us for our Diabetes Questionnaire)
___Family history of heart disease (If yes, who and at what age(s) diagnosed): _____
___Other: _____

3. Provide dates if any of the following tests or procedures (a) have been done or (b) have been recommended to be done?

___ Resting EKG: _____ ___Stress EKG: _____
___Thallium Stress EKG: _____ ___Echocardiogram: _____
___Coronary Catheterization: _____ ___Stress Echocardiogram: _____
___Valve replacement surgery - which valves? _____
___Angioplasty - what specific type? (e.g. balloon...) _____
___Bypass Surgery: _____ Number of vessels involved: _____
___Other: _____

4. Does the proposed insured take any current medications, including aspirin? ___Yes ___No
(If yes please provide name, dosage, and frequency): _____
_____
_____

5. Does the proposed insured follow a specific diet (e.g. vegetarian) or take dietary supplements (vitamins, folic acid, etc.)? ___Yes ___No (If yes, please provide details): _____
_____

6. Does the proposed insured engage in any regular exercise or sporting activity? ___Yes ___No
(If yes, please provide details): _____
_____

7. Are there any other conditions that may impact life underwriting? ___Yes ___No
(If yes, please provide details): _____
_____