MEDICAL HISTORY QUESTIONNAIRE: CARDIOMYOPATHY

Client Name: _____ Date of Birth: _____

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 Diagnosis _____

Considered: ☐ Mild ☐ Moderate ☐ Severe

2. The condition has been diagnosed as:

☐ Hypertensive cardiomyopathy
Grade: ☐ 1 ☐ 2 ☐ 3

☐ Dilated cardiomyopathy
Grade: ☐ 1 ☐ 2 ☐ 3

☐ Alcoholic cardiomyopathy
☐ When quit alcohol? _____

☐ Peripartum cardiomyopathy
☐ When recovered? _____

☐ Hypertrophic cardiomyopathy

☐ Cardiomyopathy due to valve disorder

☐ Ishcemic cardiomyopathy

☐ Congestive cardiomyopathy

☐ Restrictive or infiltrative cardiomyopathy

☐ Other: _____

3. Provide dates if any of the following tests or procedures have been done to evaluate the condition?

☐ Resting EKG: _____ ☐ Stress EKG: _____

☐ Thallium Stress EKG: _____ ☐ Echocardiogram: _____

☐ Holter Monitor: _____ ☐ Chest Xray: _____

☐ Any known abnormalities: _____

4. Does Proposed Insured know their left ventrical ejection fraction? _____ %

5. Left ventricular internal diameter (LVID): _____

6. Measurement of posterior wall (PW): _____

7. Measurement of interventricular septal wall (IVS): _____

8. Any history of Atrail Fib? ☐ Yes ☐ No

9. Any history of congestive heart failure? ☐ Yes ☐ No

10. Average blood Pressure: _____

11. Any history of arrhythmia? ☐ Yes ☐ No

12. Any family history of sudden cardiac death? ☐ Yes ☐ No

13. Please list current medications

Name of Medication	Dosage	Reason

14. Does client have any other major health issues? (additional questionnaires may be required)

☐ No ☐ Yes; please provide details _____