

## **ENLARGED HEART**

CLIENT NAME:			Date:		
CLIENT NAME: Date: Male Female Date of birth: Height:' Weight:'					
Tobacco Use: 🗆 Never used 🖾 Totally stopped Date stopped: 🗆 Use now Type of nicotine product:					
Type of Coverage: 🗆 Term 🗆 UL 🗆 Survivor 🛛 Type of Coverage: 🗆 Term 🗔 UL 🗔 Survivor UL					
Coverage Amount: Anticipated Premium:					
FAMILY HISTORY Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide? If yes, use separate sheet to provide this information, including age of onset and date of death					
PROPOSED INSURED'S EXISTING INSURANCE					
Full Name of Company	Face Amount		Year Issued	Is Policy to be Replaced?	
1. When was the condition first diagn		·			
<ul> <li>2. Have any of the following symptoms occurred?</li> <li>Chest discomforto</li> <li>Fainting spells or dizziness</li> <li>Shortness of breath</li> <li>Palpitations (irregular heart beat)</li> <li>3. Please check if your client has had any of the following:</li> <li>Chest X-ray: No Yes, Normal / Yes, Abnormal</li> <li>Exercise treadmill or thallium No Yes, Normal / Yes, Abnormal</li> <li>Resting or exercise echocardiogram No Yes, Normal / Yes, Abnormal</li> <li>MUGA No Yes, Normal / Yes, Abnormal</li> <li>Cardiac catheterization No Yes, Normal / Yes, Abnormal</li> <li>4. Is there a history of any heart disease (problems with valves, coronary artery disease, cardiomyopathy, etc.)?</li> </ul>					
□ No □ Yes; please give details					
5. Is client on any medications? (accurate name, dosage, and reason)					
(Accurate) Name of Medication		osage	Reason		

6. Does client have any other health issues? (additional questionnaires may be required) 🗆 No 👘 Yes; please give details