MEDICAL HISTORY QUESTIONNAIRE: ATRIAL FIBRILLATION

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 First Diagnosis: _____
2. Is the atrial fibrillation/flutter: _____
3. Are there any symptoms with the irregular heartbeat?
   - ☐ Blackout
   - ☐ Dizziness, light-headedness, feeling faint
   - ☐ Palpitations
   - ☐ Chest discomfort
4. Have any of the following tests been done? If so, please provide date completed and results.
   - ☐ ECG: _____
   - ☐ Stress Test: _____
   - ☐ Echocardiogram: _____
   - ☐ Holter Monitor: _____
5. Please list current medications (including aspirin):

Name of Medication	Dosage	Reason

6. The cause of the atrial fibrillation/flutter is due to:
   - ☐ Alcohol
   - ☐ Coronary Artery Disease
   - ☐ Cardiomyopathy
   - ☐ Mitral Valve Disease
   - ☐ Thyroid Disease
   - ☐ Unknown
   - ☐ Other, give details _____
7. Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes

If yes, please provide details: