



MEDICAL HISTORY QUESTIONNAIRE: ATRIAL FIBRILLATION

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage: _____ Coverage Information: _____

- 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) If yes, No Yes

please provide details:

