



An insurance Designers member since 1986

HEART DISEASE — CARDIOMYOPATHY QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of birth: _____

Face Amount: _____ Max. Premium: \$ _____ / year UL WL Term Survivorship

Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N

If Yes, please provide details: _____

When did you last use any form of tobacco: ____ (Month) ____ (Year) Type used last: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

(1) *Date of diagnosis:* _____

(2) *The condition has been diagnosed as:*

- | | |
|--|---|
| <input type="checkbox"/> Dilated cardiomyopathy | <input type="checkbox"/> Hypertrophic cardiomyopathy |
| <input type="checkbox"/> Myocarditis | <input type="checkbox"/> Idiopathic hypertrophic subaortic stenosis |
| <input type="checkbox"/> Myocardial fibrosis | <input type="checkbox"/> Alcoholic cardiomyopathy |
| <input type="checkbox"/> Myocardial degeneration | <input type="checkbox"/> Peripartum cardiomyopathy |
| <input type="checkbox"/> Congestive cardiomyopathy | <input type="checkbox"/> Restrictive cardiomyopathy |
| <input type="checkbox"/> Other: _____ | |

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

- | | |
|---|--|
| <input type="checkbox"/> Resting EKG: _____ | <input type="checkbox"/> Stress EKG: _____ |
| <input type="checkbox"/> Thallium Stress EKG: _____ | <input type="checkbox"/> Echocardiogram: _____ |
| <input type="checkbox"/> Holter Monitor: _____ | <input type="checkbox"/> Chest X-ray: _____ |
| <input type="checkbox"/> Other: _____ | |

(4) *Is there any family history of heart disease or premature death due to heart disease?*

	Age (if living)	History of heart disease?	Age at death:	Cause of death:
Mother		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sister(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Brother(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		

(5) *Does the proposed insured take any current medications?* No Yes Details:

Name of medication (prescription or otherwise)	Dates used	Quantity taken	Frequency taken

(6) *Are there any other conditions that may impact life underwriting?* If yes, please describe: _____
