# VALVULAR HEART SURGERY

**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 surgery completed? _____

2. Please note type of valve surgery:

☐ Valve replacement ☐ Valvuloplasty

☐ Commissurotomy ☐ Other _____

3. Please check the type (s) of valve disorder:

☐ Aortic stenosis ☐ Mitral stenosis ☐ Mitral valve prolapse

☐ Aortic insufficiency ☐ Mitral insufficiency

4. Please note type of valve used if replaced:

☐ Prosthetic (mechanical) ☐ Tissue (porcine or pig)

5. Have any of the following occurred?

☐ Chest pain ☐ Heart failure ☐ Palpitations ☐ Dizziness/fainting ☐ Trouble breathing

6. Is there a history of any other disease in addition to the valve disorder (coronary artery disease, etc.)? ☐ No ☐ Yes; please give details

_____

_____

7. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

| (Accurate) Name of Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

8. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

 