Mitral Valve Disorder Questionnaire

Insurance Designers of Central Texas, LLC

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Today's Date: Agent:

Full Name: Male or Female?

Height and weight: Date of Birth:

Note: We encourage you to please fax us a copy of your most recent echocardiogram, stress test, or other cardiac workup, as it will help us obtain the most accurate tentative quote.

1. List month and year diagnosed and at what age:

2. Please check the type(s) of valve disorder present:
   ____ Mitral stenosis
   ____ Mitral regurgitation
   ____ Mitral valve prolapse

3. Have any of the following occurred and date of most recent episode?

Chest pain	____ Yes ____ No	Date: ____________
Shortness of breath	____ Yes ____ No	Date: ____________
Palpitations	____ Yes ____ No	Date: ____________
Atrial fibrillation/flutter	____ Yes ____ No	Date: ____________
Pulmonary hypertension	____ Yes ____ No	Date: ____________
Premature atrial contractions (PACs)	____ Yes ____ No	Date: ____________
Premature ventricular contractions (PVCs)	____ Yes ____ No	Date: ____________

4. Is there a murmur? ____ Yes ____ No   If so, grade: ____________

5. Has there been any surgical intervention? ____ Yes ____ No
   If so, list type:
   ____ Balloon dilation   Date:____________
   ____ Open chest procedure   Date:____________
   ____ Valve replacement   Date:____________
   ____ Other______________________   Date:____________

6. When was your most recent cardiac workup and what test was it?

   ____ Nuclear stress test   Date:____________
   ____ Stress echocardiogram   Date:____________
   ____ Other______________________   Date:____________

7. What medications do you take, reason, dosage and how often?

8. How often do you see your cardiologist and when was last visit?

9. Has your weight remained stable or have you ___ lost or ___ gained weight in the past year? If so, by how much?

10. Please indicate type of tobacco EVER used:

Type:	Amount per (circle frequency):	Date last used:	Still use?
___Smokeless	___daily/monthly/yearly	___________	__Yes __ No
___Cigarettes	___per day/month/year	___________	__Yes __ No
___Cigar	___per day/month/year	___________	__Yes __ No
___Patch/Gum	___per day/month/year	___________	__Yes __ No

11. Do you have any family history of heart disease? If so, list:
    Member(s)____
    Age(s) diagnosed _________ Circle one (Current age / Age of death) __________