



## Atrial Fibrillation Questionnaire

**Agent:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Client:** \_\_\_\_\_ **DOB :** \_\_\_\_\_  *Male*  *Female*  
**Product/Face Amount:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

\* **TOBACCO/NICOTINE USE (past or present):**  **YES\*\*\***  **NO**  
 \*\*\*Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:

\* **List date and circumstances initial diagnosis if Atrial Fibrillation:**

\* **Atrial Fibrillation/Atrial Flutter has been diagnosed as:**

- Chronic* (permanent/persistent)  
 or  
 *Paroxysmal* (intermittent) – *If paroxysmal, how often do you experience recurrence of atrial fibrillation?*

\* **What, if any, of the following symptoms occur in conjunction with your Atrial Fibrillation?**

- Black-outs/Unconsciousness*  
 *Dizziness (light-headedness)/Faint feeling*  
 *Palpitations*  
 *Chest discomfort*  
 *Other:*

\* **Have any of the following diagnostic studies tests been done? If so, please provide date of most recent evaluation, frequency of follow up evaluation and results as described to you by your physician:**

- EKG* \_\_\_\_\_  
 *Stress Test* \_\_\_\_\_  
 *Echocardiogram* \_\_\_\_\_  
 *Holter Monitor* \_\_\_\_\_

\* **Has an underlying cause for the Atrial Fibrillation/Flutter been proposed?**

- Coronary Artery Disease*  
 *Alcohol Use (“Holiday Heart Syndrome”)*  
 *Thyroid disease*  
 *Mitral valve disease*  
 *Cardiomyopathy*  
 *Other (Please describe):*  
 *Cause Unknown*

\* **MEDICATIONS** - *List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:*

MEDICATION	DOSE	MEDICATION	DOSE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

\* **FAMILY HISTORY:** (Family history may be a factor in determining rate class) **Is there a family history (parent or siblings) of the following conditions/disease onset prior to age 60:**

**Cardiac Disease**     YES  NO                      **Diabetes**                       YES  NO  
**Stroke or TIA**         YES  NO                      **Cancer**                       YES  NO

Please provide details for any "YES" response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (if living)	DECEASED (list age @ time of death)
FATHER				
MOTHER				
SIBLING 1				
SIBLING 2				

\* **Do you have any other significant health issues or medical conditions not outlined or mentioned on this form?** (Complete additional questionnaires, as indicated)

**Condition** (List condition, treatment and current status)

**NONE - NO other medical conditions or health issues.**

\* **Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision as provided by the carrier and the nature of prior application/submission (formal application vs. informal/trial submission), etc.**

\* **Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?**