



Pacemaker 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.:

* Please list date when the pacemaker was implanted and provide a brief description of the symptoms and circumstances surrounding the need for the pacemaker:

*The pacemaker was implanted for:

- Heart block associated with coronary artery disease
- Complete heart block or sick sinus syndrome
- Chronic underlying atrial flutter/fibrillation
- Other (Please provide details)

* Do you have any other form of heart disease?

- YES** (Please provide details)
- NO**

*Have any of the following pacemaker complications occurred?

- Infection or blood clots
- Pacemaker malfunction or perforation of skin
- Other (Please provide details)

*Are there any continuing symptoms since the pacemaker was implanted?

- YES** (Please provide details)
- NO**

* **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)
<i>FATHER</i>				
<i>MOTHER</i>				
<i>SIBLING 1</i>				
<i>SIBLING 2</i>				

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

Condition(s) - List 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 any 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?**