

**HEART MURMUR/ MITRAL VALVE PROLAPSE QUESTIONNAIRE**

Please answer all questions pertaining to the person for which the condition applies. If you need assistance in completing this form, please contact your physician. If you need more space, please turn this sheet over and continue.

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated/relationship to applicant: \_\_\_\_\_

1. Give exact diagnosis: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

2. Have you had any of the following?

Test:	Yes	No	If yes, when?	Results were:
EKG	Yes ___ No ___	_____	Normal ___ Abnormal ___ Unknown ___	
Echocardiogram (Echo)	Yes ___ No ___	_____	Normal ___ Abnormal ___ Unknown ___	
Doppler Test	Yes ___ No ___	_____	Normal ___ Abnormal ___ Unknown ___	
Heart Catheterization	Yes ___ No ___	_____	Normal ___ Abnormal ___ Unknown ___	
Holter Monitor	Yes ___ No ___	_____	Normal ___ Abnormal ___ Unknown ___	
Thallium	Yes ___ No ___	_____	Normal ___ Abnormal ___ Unknown ___	
Stress/ Treadmill	Yes ___ No ___	_____	Normal ___ Abnormal ___ Unknown ___	

3. Have you ever experienced symptoms (chest pain, shortness of breath, dizziness, palpitations, irregular heartbeat)? \_\_\_yes \_\_\_no. If yes, please give details (date of onset, frequency, severity, date of last symptoms): \_\_\_\_\_

4. Have you ever taken medication for this condition? \_\_\_ Yes \_\_\_ No List your medication(s):

Name of Medication	Dosage	Frequency

Are you still taking this medication? \_\_\_Yes \_\_\_No If no, when did you stop? \_\_\_\_\_

5. Have you ever had surgery or has surgery/other treatment been recommended for this or any related condition?

\_\_\_Yes \_\_\_No. If yes, give details: \_\_\_\_\_

6. Have there been any hospitalization for this/these condition(s)? \_\_\_yes \_\_\_no

Name of Hospital	Address	Dates of confinement

7. Do you have any other cardiovascular conditions? \_\_\_yes \_\_\_no

If yes, please provide complete details: \_\_\_\_\_

8. Name and address of treating physician:

Name of Physician	Address	Telephone Number	Date Last Seen

It is understood and agreed that the foregoing answers are true and shall be an attachment to my application for insurance and shall be the basis for the issuance of the Membership Certificate applied for, and that the omission or misstatement of any material information in answer to the foregoing questions shall void the membership certificate.

Signature of person treated (or parent / guardian if under 18)	Date