Atrial Fibrillation

Please answer all questions applicable to the client's medical history.

Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____ ☐ Male ☐ Female

Face Amount _____ Max Premium $ _____ /yr. ☐ Term ☐ Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency _____ Date of last use _____ Type _____

Age/date when first diagnosed _____ ☐ Chronic (permanent) ☐ Paroxysmal (intermittent)

Current medications _____

What is the cause of the atrial fibrillation? _____

Average number of episodes per year _____ Date of last episode _____

Has the client ever had an ablation procedure? If yes, please advise date _____

Has the client ever had a cardioversion? If yes, please advise date _____

Does the client have a pacemaker or defibrillator implanted? If yes, please advise:

Type _____ Date of implant _____

Does the client have

☐ High blood pressure, reading(s) _____ Date _____

☐ High cholesterol, total cholesterol ☐ HDL ☐ LDL ☐ Ratio Date _____

Have any of the following tests been done

	Date(s)	Results
☐ EKG		
☐ Stress test		
☐ Echocardiogram		
☐ Holter monitor		
☐ Other		

List any other major health problems the client has: