



# Arrhythmia Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: M/F

Tobacco Usage: \_\_\_\_\_ Face Amount: \_\_\_\_\_

\_\_\_Term 10 15 20 30 \_\_\_UL

### 1. Has the proposed insured had any of the following?

- \_\_\_ Chest pain or Angina Dates: \_\_\_\_\_
- \_\_\_ Heart attack(s) Dates: \_\_\_\_\_
- \_\_\_ Bypass surgery Dates: \_\_\_\_\_ How many Vessels? \_\_\_\_\_
- \_\_\_ Angioplasty Dates: \_\_\_\_\_ How many Vessels? \_\_\_\_\_
- \_\_\_ Atherectomy Dates: \_\_\_\_\_ How many Vessels? \_\_\_\_\_

\*If Stents were placed at the time of Angioplasty, how many, per date? \_\_\_\_\_

- \_\_\_ Heart Valve Disease Date of Diagnosis: \_\_\_\_\_
- \_\_\_ Abnormal heart rhythm or pulse Date of Diagnosis: \_\_\_\_\_
- \_\_\_ Heart Murmur Date of Diagnosis: \_\_\_\_\_
- \_\_\_ Atrial fibrillation or flutter Date of Diagnosis: \_\_\_\_\_

A. Is the diagnosis? \_\_\_Chronic or \_\_\_Paroxysmal

B. Cause? \_\_\_Alcohol \_\_\_Cardiomyopathy \_\_\_Heart valve disease  
\_\_\_Coronary Heart Disease \_\_\_Unknown or other \_\_\_\_\_

### 2. Has the proposed insured had any of the following symptoms?

\_\_\_Chest discomfort \_\_\_Black-out \_\_\_Palpitations \_\_\_Dizziness/faint feeling

### 3. What has been used to get the heart back to the normal rhythm?

- Date: \_\_\_\_\_ Method used: \_\_\_\_\_
- Date: \_\_\_\_\_ Method used: \_\_\_\_\_
- Date: \_\_\_\_\_ Method used: \_\_\_\_\_
- Date: \_\_\_\_\_ Method used: \_\_\_\_\_

### 4. Is the proposed insured taking medication or this condition or any other? \_\_\_Yes \_\_\_No

(If yes, please provide name, dosage, and frequency): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_