# Cardiomyopathy Questionnaire

Name: __________________________ Date of Birth: _________________________

Height: __________ Weight: _________ Sex: M/F

Tobacco Usage: ___________________ Face Amount: _______________________

___Term 10 15 20 30 ___UL

1. When was the proposed insured diagnosed?______________________________________

2. The condition has been diagnosed as:
___ Dilated cardiomyopathy ___ Hypertrophic cardiomyopathy ___ Restrictive cardiomyopathy
___ Other: ______________________________________________________________

3. Does the proposed insured suffer from any of the following symptoms? (Check all that apply)
___ Chest pain or pressure ___shortness of breath ___fatigue
___Swelling of lower extremities ___weight gain ___fainting
___Palpitations ___dizziness

4. Has the proposed insured undergone any of the following procedures?
___Pacemaker Date: _______________________
___Implantable cardioverter defibrillator Date: _______________________
___Other __________________________ Date: ______________________

5. Is there a family history of heart disease? ___Yes ___No
(If yes, please provide relationship to proposed insured and date of onset and/or death): ___________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

6. Is the proposed insured taking any medication? ___Yes ___No
(If yes, please provide name, dosage, and frequency): ________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________