



## Heart Block 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 with heart blockage?

\_\_\_\_\_

2. What type of heart block has been diagnosed?

\_\_\_First-degree (AV block)    \_\_\_Type I second-degree    \_\_\_Type II second-degree  
\_\_\_Third-degree    \_\_\_Complete Heart Block    \_\_\_Bundle Branch Block  
\_\_\_Trifascicular block    \_\_\_Left Bundle    \_\_\_Right bundle

3. Does the proposed insured suffer from any of the following symptoms? (Check all that Apply)

\_\_\_ Syncope (fainting)    \_\_\_Dizziness    \_\_\_Lightheadedness    \_\_\_Chest Pain    \_\_\_Shortness of breath

4. Has the proposed insured undergone any of the following procedures?

\_\_\_Pacemaker    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 for this condition or any other? \_\_\_Yes \_\_\_No

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_