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?_____

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 ___Trifasciular block
    1. ___Left Bundle
    2. ___Right bundle

3. Does the proposed insured suffer from any of the following symptoms:
___ 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 the proposed insured taking any medication? ___Yes ___No
If yes, please provide name, dosage and frequency:
_____
_____
_____

6. 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:
_____
_____
_____