



Arrhythmia History

Client Name _____ Date of Birth ____/____/____ Smoker Y N
Height ____' ____" Weight _____ lbs. Amt. of ins \$._____ Type: Term Yrs.____ GUL UL WL
Have you ever been declined or rated for insurance? Y N Details: _____

Have you experienced Irregular Heart Beat Y N Date(s) _____
Is your Irregular Heart Beat due to: (Circle all that apply) Premature Supraventricular Atrial Beats (PAC's) Chronic Atrial Flutter or Fibrillation (AF) Paroxysmal Atrial Flutter or Fibrillation (AF)

Have you experienced any of the following symptoms? (Circle all that apply) Black-Out Dizziness Palpitations Chest Discomfort
Is the cause of the Irregular Heart Beat due to: (Circle all that apply) Heart Disease Alcohol Thyroid Disease Unknown

Have you ever had a Heart Attack? Y N If YES Date(s) _____

Have you had a Treadmill EKG or any type of Stress Test? If so, When? _____ Were the results normal? _____

Do you experience any Chest Pains now? Y N

Have you had a pacemaker installed? Y N When? _____ A Defibrillator? Y N When? _____

What have been your recent Blood Pressure readings? -----

What has been your recent Cholesterol readings? -----

Do you have Diabetes? Y N When Diagnosed? _____ Recent A1C? _____

If YES, what medication are you taking? _____

Do you have any Family History of Heart Disease or Diabetes? Y N

What Lifestyle Changes have you made to treat your illness? _____

Please list all medications being taken: _____

Do you have any other major health problems? (example: cancer, etc)? _____

Broker Submitting Questionnaire: _____

Address _____

Phone _____ FAX: _____

E-Mail _____