



HEART MURMUR/ MITRAL VALVE PROLAPSE QUESTIONNAIRE (Complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Give exact diagnosis: _____ Date of diagnosis: _____

2. Description of murmur (check one): functional organic diastolic systolic
_____ other (specify)

3. Have you had any of the following?

Test:	Yes	No	If yes, when?	Normal	Abnormal	Results were:
EKG	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Unknown <input type="checkbox"/>
Echocardiogram (Echo)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Unknown <input type="checkbox"/>
Doppler Test	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Unknown <input type="checkbox"/>
Heart Catherization	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Unknown <input type="checkbox"/>
Holter Monitor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Unknown <input type="checkbox"/>
Thallium	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Unknown <input type="checkbox"/>
Stress/ Treadmill	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Unknown <input type="checkbox"/>

4. Have you ever experienced symptoms (chest pain, shortness of breath, dizziness, palpitations, irregular heartbeat)? Yes No. If yes, please give details (**date of onset, frequency, severity, date of last symptoms**):

5. Have you ever taken medication for this condition? Yes No
Name Medication: Dosage: Frequency (ie.daily,as needed) If no longer taking, date stopped:

6. Have you ever had surgery or has surgery or other treatment been recommended for this or any related condition? Yes No.
If yes, give details: _____

7. Has there been any hospitalization for this or any other related condition? Yes No.
If yes, dates of confinement(s): _____ Length of stay(s): _____
Name and address of hospital(s) where confined: _____

8. Do you have any other cardiovascular conditions? Yes No. If yes, please provide complete details:

9. Name and address of treating physician: _____

10. What is your current height? _____ weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that the insurer will rely on these statements when determining eligibility.

Signature of person treated (or parent / guardian if under 18)

Date

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