



# 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?

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

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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