

# Heart Murmur Questionnaire

Agent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male /  Female  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ State: \_\_\_\_\_ Smoker:  Y /  N Face Amount: \_\_\_\_\_  
Type of Insurance:  Universal Life  Whole Life  Survivorship  Term (# of years \_\_\_\_\_)

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1. When was the proposed insured first diagnosed with a heart murmur? \_\_\_\_\_

2. Has the proposed insured been diagnosed with any of the following? (Check all that apply.)

Light headedness     Breathlessness     Blackouts     Aortic regurgitation  
 Edema     Marfan's Syndrome     Fatigue     Rapid heartbeat  
 Other: \_\_\_\_\_

3. What kind of heart murmur was diagnosed?

Diastolic     Systolic     Stenotic heart valve  
 Aortic or mitral regurgitation     Other: \_\_\_\_\_

4. When did the proposed insured last have the following?

Electrocardiogram (ECG)    Date: \_\_\_\_\_  
 Chest x-ray    Date: \_\_\_\_\_  
 Echocardiogram    Date: \_\_\_\_\_

5. Does the proposed insured have any restrictions for activities?  Yes  No

If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_

6. Does the proposed insured have any family history of heart disease?  Yes  No

If yes, provide relationship to proposed insured and date of onset and/or death: \_\_\_\_\_  
\_\_\_\_\_

7. Is the proposed insured current taking any medication(s)?  Yes  No

If yes, provide name, dosage and frequency of medication(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAX TO 603-778-7918 or E-MAIL TO [sdonovan@uuinc.com](mailto:sdonovan@uuinc.com).**