

**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. Have 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