Phone: 888.227.3131
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American Brokerage Services
The Career Company for Independent Agents

Atrial Fibrillation Questionnaire

Agent: _____ ***Phone:*** _____ ***Fax:*** _____
Client: _____ ***DOB :*** _____ ***Male Female***
Product/Face Amount: _____ ***Height:*** _____ ***Weight:*** _____

- **TOBACCO/NICOTINE USE (*past or present*): YES*** NO**
  ****Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:*

- **List date and circumstances initial diagnosis if Atrial Fibrillation:**

- **Atrial Fibrillation/Atrial Flutter has been diagnosed as:**

  Chronic (permanent/persistent)
  or
  Paroxysmal (intermittent) – *If paroxysmal, how often do you experience recurrence of atrial fibrillation?*

- **What, if any, of the following symptoms occur in conjunction with your Atrial Fibrillation?**

  Black-outs/Unconsciousness
  Dizziness (light-headedness)/Faint feeling Palpitations
  Chest discomfort
  Other:

- **Have any of the following diagnostic studies tests been done? If so, please provide date of most recent evaluation, frequency of follow up evaluation and results as described to you by your physician:**

  *EKG*_____
  Stress Test _____
  Echocardiogram _____
  *Holter Monitor*_____

- **Has an underlying cause for the Atrial Fibrillation/Flutter been proposed?**

  Coronary Artery Disease
  Alcohol Use ("Holiday Heart Syndrome") Thyroid disease
  Mitral valve disease
  Cardiomyopathy
  Other (Please describe):
  Cause Unknown

- **MEDICATIONS -** *List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:*

MEDICATION	DOSE	MEDICATION	DOSE
1.		***5.***	
2.		***6.***	
3.		***7.***	
4.		***8.***	

- **FAMILY HISTORY:** (*Family history may be a factor in determining rate class*) **Is there a family history (*parent or siblings*) of the following conditions/disease onset prior to age 60:**

Cardiac Disease	**YES**	**NO**	***Diabetes***	**YES**	**NO**
Stroke or TIA	**YES**	**NO**	***Cancer***	**YES**	**NO**

Please provide details for any "YES" response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (*if living*)	DECEASED (*list age @ time of death*)
FATHER				
MOTHER				
SIBLING 1				
SIBLING 2				

- **Do you have any other significant health issues or medical conditions not outlined or mentioned on this form?** (*Complete additional questionnaires, as indicated*)

  Condition (*List condition, treatment and current status)*

  NONE - ***NO other medical conditions or health issues.***

- **Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision as provided by the carrier and the nature of prior application/submission (formal application vs. informal/trial submission), etc.**

- **Are there *any* other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?**