NAILBA
NAILBA University

MITRAL VALVE DISORDER

CLIENT NAME: ____ **Date:** ______________________

☐ Male ☐ Female Date of birth: ___________ Height: _____' _____" Weight: ___________

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: ___________ ☐ Use now Type of nicotine product: ____________

Type of Coverage: ☐Term ☐UL ☐ Survivor ☐ Disability **Coverage Amount:** ______________________

Annual Income:____________________ **Occupation/Job duties:** ______________________ **State of Residence:** __________________

Anticipated Premium: ________________________

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. How long has this abnormality been present? ____

2. Please check the type(s) of valve disorder present:

☐ Mitral stenosis ☐ Mitral regurgitation ☐ Mitral valve prolapse

3. Have any of the following occurred?

Chest pain ☐ No ☐ Yes

Trouble breathing ☐ No ☐ Yes

Heart failure ☐ No ☐ Yes

Palpitations ☐ No ☐ Yes

Atrial fibrillation/flutter ☐ No ☐ Yes

Has client received any treatment for this condition? If so, please provide dates and details: ____________________________________

4. Is there a history of any other heart disease in addition to the mitral valve disorder (problems with other valves,

coronary artery disease, etc.)? ☐ No ☐ Yes; please give details

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5. Have additional studies been completed? (check all that apply)

☐ Echocardiogram Date: __________________________

☐ Cardiac catheterization Date: __________________________

☐ None

6. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

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