



Cardiac Arrhythmia Questionnaire (no heart disease)

Insurance Designers of Central Texas, LLC
12466 Los Indios Trail #100 Austin, TX 78729
Phone 512-257-9700 FAX 512-257-9701

Today's Date: _____ Agent: _____
Full Name: _____ Male or Female? _____
Height and weight: _____ Date of Birth: _____

1. When were you diagnosed with a cardiac arrhythmia (month and year)?

2. What type of arrhythmia was it?

- | | |
|--|---|
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Atrial flutter |
| <input type="checkbox"/> Ventricular fibrillation | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Bradycardia |
| <input type="checkbox"/> Premature atrial contractions (PACs) | |
| <input type="checkbox"/> Premature ventricular contractions (PVCs) | |
| <input type="checkbox"/> Sick sinus syndrome | |

3. How often does the arrhythmia occur?

4. When was your most recent cardiac workup and what test was it?

- | | |
|--|-------------|
| <input type="checkbox"/> Nuclear stress test | Date: _____ |
| <input type="checkbox"/> Stress echocardiogram | Date: _____ |
| <input type="checkbox"/> Resting EKG | Date: _____ |
| <input type="checkbox"/> Other | Date: _____ |

NOTE: If you are able to get a copy of this test from your doctor, please fax it to us as it will help with getting a more solid tentative offer from the insurance company.

5. What medication do you take, reason, dosage and how often?

6. Has your weight remained stable in the past year? Yes No
If no: Lost _____ pounds OR Gained _____ pounds

7. Please indicate type of tobacco EVER used:

Type:	Amount per (circle frequency):	Date last used:	Still use?
<input type="checkbox"/> Smokeless	<input type="checkbox"/> daily/monthly/yearly	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigarettes	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigar	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Patch/Gum	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Do you have any family history of heart disease? Yes No
If yes, list member and current age or age deceased.