HEART FAILURE

CLIENT NAME: ____

Submit the Client Information Questionnaire with this form

1. What was the cause of heart failure? ____________________________

2. When was the diagnosis made? ____________________________

3. Has client had surgical heart repair?

   ___Yes; type: ________________ date: ________________
   ___No

4. Does client have a history of any of the following (please provide details or complete the questionnaire for the condition):

   ___Hypertension ____
   ___Coronary artery disease __________________________________
   ___Chronic obstructive pulmonary disease ________________________
   ___Pacemaker ____

5. Has an angiogram, echocardiogram, stress test, or heart scan been done?

   ___Yes; please provide details ________________
   ___No

6. Is client on any medications? (accurate name, dosage, and reason)

7. Does your client have any other major health problems? (additional questionnaires may be required

Producer Name:____

Please fax form to 612-392-7644 or email to mvp@mvpservicesolutions.com

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