MITRAL VALVE DISORDER

PRODUCER NAME:___________________________________

CLIENT NAME: ____

Submit the Client Information Questionnaire with this form

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	__yes __no
Trouble breathing	__yes __no
Heart failure	__yes __no
Palpitations	__yes __no
Atrial fibrillation/flutter	__yes __no

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.)?
   __yes; give details: ____
   __no

5. Have additional studies been completed? (check all that apply)
   __echocardiogram ________________________(date)
   __cardiac catheterization ________________________(date)
   __none

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

7. Are there any other health problems? (additional questionnaires may be required)

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