MITRAL VALVE PROLAPSE

PRODUCER NAME:_____

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. How long has this abnormality been present?

2. Have any of the following symptoms occurred? (check all that apply)

fainting or dizziness	_____yes	_____no
palpitations	_____yes	_____no
shortness of breath	_____yes	_____no
chest pain	_____yes	_____no

3. Is there a history of any other heart disease in addition to the mitral valve prolapse (problems with other valves, coronary artery disease, etc.)?

☐ yes (please submit a copy of the report)

☐ no

4. Has an echocardiogram (ultrasound of the heart) been done?

☐ yes (please submit a copy of the report)

☐ no

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

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

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

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