

# CONGESTIVE HEART FAILURE

**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 **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

## FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: \_\_\_\_\_

2. What is the cause of the CHF? \_\_\_\_\_

3. Has the client had surgical heart repair?

No  Yes; type: \_\_\_\_\_ Date: \_\_\_\_\_

4. Does client have a history of any of the following? (provide details)

Hypertension \_\_\_\_\_

Coronary artery disease \_\_\_\_\_

Chronic obstructive pulmonary disease \_\_\_\_\_

Pacemaker \_\_\_\_\_

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

No  Yes; please give details and provide a copy if available \_\_\_\_\_

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

(Accurate) Name of Medication	Dosage	Reason

7. Does client have any other health issues? (additional questionnaires may be required)  No  Yes; please give details

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