VALVULAR HEART SURGERY

Producer Name:____________________________________

CLIENT NAME: ____--

Submit the Client Information Questionnaire with this form

1. When was the surgery completed?________________(date)

2. Please note type of valve surgery:

   _____Valve replacement _____Valvuloplasty

   _____Commissurotomy _____Other

3. Please check the type (s) of valve disorder:

   _____ Aortic stenosis
   _____ Aortic insufficiency
   _____ Mitral stenosis
   _____ Mitral insufficiency
   _____ Mitral valve prolapse

4. Please note type of valve used if replaced:

   _____ Prosthetic (mechanical) _____ Tissue (porcine or pig)

5. Have any of the following occurred?

   Chest pain _____yes _____no
   Heart failure _____yes _____ no

   Palpitations _____yes _____no
   Dizziness/fainting _____yes _____no

   Trouble breathing _____yes _____no

6. Is there a history of any other disease in addition to the valve disorder? (coronary artery disease, etc.)

   _____ Yes; please give details ____
   _____ No

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

8. 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

©Copyright July 2006. The National Association of Independent Life Brokerage Agencies (NAILBA). All rights reserved.