HEART MURMUR QUESTIONNAIRE

Reset Form

Name	Date of birth (dd/mmm/yy)	Application #

1. Condition (if heart murmur, please state type of murmur):

When did the first symptom occur or when was the condition first detected?

Has any specific cause been identified for your condition?

How often do symptoms occur and how long do they last?

When did you last have symptoms?

Date & results of last ECG, Echocardiogram, Stress test, MIBI or Thallium:

Do you have any tests pending? If so, please state test & scheduled date:

2. Do you or have you suffered from: ◯ Fainting ◯ Dizziness ◯ Chest pain
Shortness of breath when lying down ◯ Heart rhythm disturbance

Are you currently experiencing any symptoms? ◯ yes ◯ no If yes, describe current symptoms:

If no, how long have you been symptom free?

Name address & phone number of medical advisor(s) consulted:

Date of last medical advisor consult (dd/mm/yy):

Details of any medication taken (type, dose, frequency):	Still taking medication	Date medication was stopped
	◯ yes ◯ no	
	◯ yes ◯ no	
	◯ yes ◯ no	
	◯ yes ◯ no	

Have you ever been advised to take prophylactic antibiotics before surgery or dental work? ◯ Yes ◯ no

3. Have you ever been hospitalized for this condition? ◯ yes ◯ no If yes, please give details below.

Have you ever required emergency treatment for this condition? ◯ yes ◯ no If yes, please give details below.

Is there any physical restriction or impairment because of your condition? ◯ yes ◯ no If yes, please give details below.

Have your job duties or leisure activities been affected in any way or have you lost any time from work because of your condition?
◯ Yes ◯ No If yes, please give details below.

Do any of your family members have heart related problems? ◯ yes ◯ no If yes, please give details below.

I hereby declare that the above answers are complete and true, and agree that they shall form part of my application for the policy requested.

Signature of Applicant	Signature of Witness	Date (dd/mmm/yy)
X	X	

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