PACEMAKER

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 the pacemaker was implanted: _____

2. The pacemaker was implanted for:

☐ Heart block associated with coronary artery disease
☐ Complete heart block or sick sinus syndrome
☐ Chronic underlying atrial flutter/fibrillation
☐ Other; give details _____

3. Does client have another heart disease? Give details:

_____

4. Have any of the following pacemaker complications occurred?

☐ Infection ☐ Blood clots ☐ Pacemaker malfunction ☐ Perforation

☐ Other; please give details _____

5. Are there any continuing symptoms since the pacemaker was implanted? ☐ No ☐ Yes; please give details

_____

_____

6. When was client's last checkup? _____

7. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

8. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

