Client Name:			MEDICAL	HISTORY Q	UESTION	NAIRE: F	PACEMAK
Tobacco Usage: Coverage Information: Never Type: Former Date Stopped: Current Type: Premium Tolerance: Premium Tolerance: Proposed Insured's Existing Insurance Insurance Company Face Amount Year Issued Replacement (Yes/No I. Date the pacemaker was implanted: 2. The pacemaker was implanted for: Heart block associated with CAD Chronic underlying atrial fibrillation/flutter Other, give details: 3. Does client have another heart disease? No Yes If Yes, please provide details:	Client Name:			Date o	of Birth:		
Never Type: Term UL IUL Former Date Stopped: WL WL VUL Survivorsh Current Type: Premium Tolerance: Premium Tolerance: Premium Tolerance: Insurance Company Face Amount Year Issued Replacement (Yes/No 1. Date the pacemaker was implanted:	Gender: 🔲 Male 🗌	Female Height:			Weight:		
Insurance Company Face Amount Year Issued Replacement (Yes/No Image: Image	Never Former Date S		Type: Face Am	Term WL nount:	🛛 VUL		Survivorshi
1. Date the pacemaker was implanted: 2. The pacemaker was implanted for: Heart block associated with CAD Chronic underlying atrial fibrillation/flutter Other, give details: 3. Does client have another heart disease? No Yes If Yes, please provide details: Image: A state of the following pacemaker complications occurred? Image: A state of the following pacemaker complications occurred?		Proposed Ins	ured's Existing	Insurance			
2. The pacemaker was implanted for: Complete heart block or sick sinus syndrome Heart block associated with CAD Complete heart block or sick sinus syndrome Chronic underlying atrial fibrillation/flutter Other, give details: 3. Does client have another heart disease? No Yes If Yes, please provide details: Have any of the following pacemaker complications occurred? Infection Blood Clots Pacemaker Malfunction	Insurance Company	Face Amount		Year Issued		Replaceme	nt (Yes/No)
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Infection Blood Clots Pacemaker Malfunction	Heart block associatedChronic underlying atri	with CAD al fibrillation/flutter	Other, g	ive details:			letails:
	Infection	Blood Clots D Pa		unction			
5. Are there any continuing symptoms since the pacemaker was installed? No Yes If Yes, please provide details:					□ No		Yes
6. When was the client's last checkup?	6. When was the client's last cl						
7. Please list current medications:							
Name of Medication Dosage Reason	Name of Medicat	on De	osage		Rea	ison	
8. Are there any other health issues? (Additional Questionnaires may be required) If yes, please provide details:	•		-		C	No	Yes
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