FPG
FINANCIAL PROFESSIONALS GROUP

# Atrial Fibrillation Questionnaire

Clear Form

Name DOB Gender Male

| | |
|---|---|
| Desired face amount and type of coverage: | |
| Height and Weight: | |
| Date of or Age at Diagnosis: | |
| Is the a-fib chronic (permanent) or paroxysmal (Intermittent)? | |
| If paroxysmal, how often does a-fib occur? | |
| Any symptoms with the irregular heart beat? | |
| Have any of the following tests been done? If yes, provide date and results | ☐ Stress test: _____<br>☐ Holter Monitor: _____<br>☐ Echocardiogram: _____ |
| Does the client have a pacemaker? | |
| The cause of the fibrillation/flutter is due to: | ☐ Coronary heart disease ☐ Alcohol<br>☐ Thyroid disease ☐ Cardiomyopathy<br>☐ Valve disease ☐ Hypertension<br>☐ Sick sinus syndrome ☐ Unknown or Other |
| Medications currently being taken (provide dosage and frequency): | |
| Does the client currently smoke or ever smoked? If yes, provide date of last tobacco use: | |
| Has the client ever had any other major medical conditions? Provide diagnosis date, treatment, results, etc. | |

**Please return the completed form to your financial professional.**

All quotes are tentative, and are NOT BINDING, and SUBJECT TO full underwriting which may include exams, labs, doctor records, and/or any other information obtained during the underwriting process.