



## Atrial Fibrillation

Please answer all questions applicable to the client's medical history.

Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Face Amount \_\_\_\_\_ Max Premium \$ \_\_\_\_\_ /yr.  Term  Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)?  Yes  No

Frequency \_\_\_\_\_ Date of last use \_\_\_\_\_ Type \_\_\_\_\_

Age/date when first diagnosed \_\_\_\_\_  Chronic (permanent)  Paroxysmal (intermittent)

Current medications \_\_\_\_\_

What is the cause of the atrial fibrillation? \_\_\_\_\_

Average number of episodes per year \_\_\_\_\_ Date of last episode \_\_\_\_\_

Has the client ever had an ablation procedure? If yes, please advise date \_\_\_\_\_

Has the client ever had a cardioversion? If yes, please advise date \_\_\_\_\_

Does the client have a pacemaker or defibrillator implanted? If yes, please advise:

Type \_\_\_\_\_ Date of implant \_\_\_\_\_

Does the client have

High blood pressure, reading(s) \_\_\_\_\_ Date \_\_\_\_\_

High cholesterol, total cholesterol  HDL  LDL  Ratio Date \_\_\_\_\_

Have any of the following tests been done

	Date(s)	Results
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Stress test	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____
<input type="checkbox"/> Holter monitor	_____	_____
<input type="checkbox"/> Other	_____	_____

List any other major health problems the client has:

### Questions?

Please call your McGill Brokerage Marketing Team at 800-279-0751.