



MEDICAL HISTORY QUESTIONNAIRE: PACEMAKER

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage: Never Former Current
 Date Stopped: _____ Type: _____

Coverage Information: Type: Term UL IUL
 WL VUL Survivorship
 Face Amount: _____
 Premium Tolerance: _____

| Proposed Insured's Existing Insurance | | | |
|---------------------------------------|-------------|-------------|----------------------|
| Insurance Company | Face Amount | Year Issued | Replacement (Yes/No) |
| | | | |
| | | | |
| | | | |

1. Date the pacemaker was implanted: _____

2. The pacemaker was implanted for:
 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: _____

4. Have any of the following pacemaker complications occurred?
 Infection Blood Clots Pacemaker Malfunction
 Perforation Other, give details: _____

5. Are there any continuing symptoms since the pacemaker was installed? No Yes
 If Yes, please provide details: _____

6. When was the client's last checkup? _____

7. Please list current medications:

| Name of Medication | Dosage | Reason |
|--------------------|--------|--------|
| | | |
| | | |
| | | |

8. Are there any other health issues? (Additional Questionnaires may be required) No Yes
 If yes, please provide details: _____