

MITRAL VALVE DISORDERS

Client's Name _____

If your client has had mitral stenosis and/or insufficiency, please answer the following:

1. How long has this abnormality been present? _____ (years)

2. Have any of the following occurred?

| | | |
|-----------------------------|------------------------------|-----------------------------|
| chest pain | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| trouble breathing | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| heart failure | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| palpitations | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| atrial fibrillation/flutter | <input type="checkbox"/> yes | <input type="checkbox"/> no |

3. Is there a history of any other heart disease in addition to the mitral valve disorder (problems with other valves, coronary artery disease, etc.)?
 yes, please give details _____
 no

4. Have additional studies been completed? (check all that apply)

| | | |
|--|-------|--------|
| <input type="checkbox"/> echocardiogram | _____ | (date) |
| <input type="checkbox"/> cardiac catheterization | _____ | (date) |
| <input type="checkbox"/> none | | |

5. Is your client on any medications?
 yes, please give details _____
 no

(2)

6. Has your client smoked cigarettes in the last 12 months?

yes

no

7. Does your client have any other major health problems (example: cancer, etc.)?

yes, please give details _____

no

Agents name:

Agents Tell #

Agent Fax #

Date Submitted:

Agents e-mail address:

PLEASE FAX TO BEST MARKETING AT 1-781 643-2775