AORTIC VALVE DISORDERS

Client's Name ____

If your client has an Aortic Valve Disorder, please answer the following:

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

2. Have any of the following occurred?

chest pain	☐ yes	☐ no
palpitations	☐ yes	☐ no
trouble breathing	☐ yes	☐ no
dizziness	☐ yes	☐ no
heart failure	☐ yes	☐ no

3. Is there a history of any other heart disease in addition to the aortic 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)
   - ☐ echocardiogram ________________________ (date)
   - ☐ cardiac catheterization ________________________ (date)
   - ☐ none

5. Is your client on any medications?
   - ☐ yes, please give details ____
   - ☐ no

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

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