



J.L. Thomas & Company

A LIFEMARK PARTNER

The strength of many. The power of one.

Aortic Valve Disorders - Ask "Rx" pert underwriter (ask our experts)

Producer _____ Phone _____ Fax _____

Client _____ Age/DOB _____ Sex _____

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

- How long has this abnormality been present? _____ (years)
- Please check the type(s) of aortic valve disorder present:
 Aortic stenosis
 Aortic sclerosis
 Aortic insufficiency
- Have any of the following occurred?

<input type="checkbox"/> chest pain	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> palpitations	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> trouble breathing	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> dizziness, fainting	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> heart failure	<input type="checkbox"/> yes	<input type="checkbox"/> no
- 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
- Have additional studies been completed? (check all that apply)
 echocardiogram _____ (date)
 cardiac catheterization _____ (date)
 none
- Is your client on any medication?
 yes, please give details _____
 no
- Has your client smoked cigarettes in the last 12 months?