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Supplement to ConnectiCare® SOLO Application
HEART MURMUR/ MITRAL VALVE PROLAPSE QUESTIONNAIRE

Name of primary applicant: _____ ID/SSN: _____.

Name of person related to condition: _____.

1. Give exact diagnosis: _____ Date of diagnosis: _____.

2. Description/type of murmur (check one):

Functional Organic Diastolic Systolic Atrial/Ventricular Septal Defect

3. Have you had any of the following tests? If yes, when and what were the results?

EKG	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/>
Echocardiogram (Echo)	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/>
Doppler Test	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/>
Heart Catheterization	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/>
Holter Monitor	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/>
Thallium	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/>
Stress/ Treadmill	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/>

4. Have you ever experienced symptoms such as chest pain, shortness of breath, dizziness, palpitations, irregular heartbeat, etc.? Yes or No: _____. If yes, please give details (date of onset, frequency, and severity): _____.

5. What was the date of your last symptom? _____.

6. Have you ever taken medication for this condition? Yes or No: _____. If yes, please provide the name of the medication, dosage and the frequency with which you take it:
_____. If no longer taking, date stopped: _____.

7. Have you ever had surgery or had surgery or any other treatment recommended for this or any other related condition? Yes or No: _____. If yes, give details:
_____.

8. Have there been any hospitalizations for this or any other related condition? Yes or No: _____. If yes, provide dates of confinement(s), length of stay(s), and the name and address of hospital(s) where confined:

_____.

9. Do you have any other cardiovascular conditions? Yes or No: _____. If yes, provide complete details:
_____.

10. Name and address of current treating physician:
_____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent/guardian if under 18): _____.

Today's Date: _____.