MITRAL VALVE DISORDER

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. How long has this abnormality been present? _____

2. Please check the type(s) of valve disorder present:
   __mitral stenosis
   __mitral regurgitation
   __mitral valve prolapse

3. Have any of the following occurred?
   Chest pain __yes __no
   Trouble breathing __yes __no
   Heart failure __yes __no
   Palpitations __yes __no
   Atrial fibrillation/flutter __yes __no

4. 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; give details: _____
   __no

5. Have additional studies been completed? (check all that apply)
   __echocardiogram _____(date)
   __cardiac catheterization _____(date)
   __none

6. Is client on any medication? (accurate name, dosage, and reason)

7. Are there any other health problems? (additional questionnaires may be required)