MITRAL VALVE PROLAPSE

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. How long has this abnormality been present?

2. Have any of the following symptoms occurred? (check all that apply)

fainting or dizziness ____yes _____no
palpitations ____yes _____no
shortness of breath ____yes _____no
chest pain ____yes _____no

3. Is there a history of any other heart disease in addition to the mitral valve prolapse (problems with other valves, coronary artery disease, etc.)?

____yes (please submit a copy of the report)

____no

4. Has an echocardiogram (ultrasound of the heart) been done?

____yes (please submit a copy of the report)

____no

5. Is client on any medications? (accurate name, dosage, and reason)

6. Does your client have any other major health problems? (additional questionnaires may be required)