

STROKE (CVA) / MINI STROKE (TIA) QUESTIONNAIRE

Agent: _____

Phone: _____

Fax: _____

Proposed Insured Name: _____ M F Date of Birth: _____
 Face Amount: _____ Max. Premium: \$ _____ /year UL WL Term Survivorship
 Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): Y N
 If Yes, please provide details: _____
 When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____

(1) *Date(s) of Strokes (CVAs) or Mini Strokes (TIAs):* _____

(2) *What follow up studies were done following the reported Stroke (CVA) or Mini Stroke (TIA) (please check all that apply)?*

- CT Scan MRI Scan Carotid ultrasound
 Echocardiogram Other: _____

(3) *Is the proposed insured taking any medications? If yes:*

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(4) *Has the proposed insured been diagnosed with any of the following conditions:*

- Hypertension? What is the most current reading? _____
 Elevated Cholesterol? What is the most recent reading? _____
 Heart Attack (MI)? Date(s): _____
 Diabetes? Date of diagnosis: _____ How controlled? _____ Most recent A1C test result: _____
 Coronary Artery Disease (CAD)? Date of diagnosis & details: _____
 Peripheral Vascular Disease? Date of diagnosis & details: _____
 Valve Disorders? Date of diagnosis & details: _____
 Cardiomyopathy? Date of diagnosis & details: _____
 Atrial Fibrillation? Date of diagnosis & details: _____

(5) *Describe any symptoms experienced at the time of the Stroke (CVA) or Mini Stroke (TIA):* _____

(6) *Describe any residual neurologic deficits or other residual effects from the Stroke (CVA):* _____

(7) *Does the proposed insured have any other medical conditions? If yes, please describe:*
