



Stroke Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M F

Tobacco Usage: _____
____Term 10 20 30

Face Amount: _____
____UL

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. 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 (Date): _____

___ Diabetes (Date of diagnosis) _____ (Sugar reading) _____
Most recent A1C test result: _____

___ Coronary Artery Disease (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) _____

4. Describe any residual neurological deficits or other residual effects from the Stroke:

5. Does the proposed insured have any other medical conditions? ___ Yes ___ No

(If yes, please describe) _____

6. Is the proposed insured taking any medication? ___ Yes ___ No.

(If yes, please provide name, dosage, and frequency)
