Stroke Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. Which of the following did the proposed insured experience?
   ___ Stroke (CVA) Date(s): _____
   ___ Mini Stroke (TIA) Date(s): _____

2. What follow-up studies were done following the stroke or mini stroke?
   ___ CT Scan ___ MRI Scan ___ Carotid ultrasound ___ Echocardiogram
   ___ Other: _____

3. Has the proposed insured been diagnosed with any of the following conditions? (Check all that apply.)

   ___ Hypertension Most current reading? _____
   ___ Elevated Cholesterol Most current reading? _____
   ___ Heart Attack Date(s): _____
   ___ Diabetes Date of diagnosis: _____ Sugar: _____
   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: _____
   ___ Other: _____

4. Describe any residual neurologic deficits or other residual effects from the stroke or mini stroke:
   _____

5. Does the proposed insured have any other medical conditions? ___ Yes ___ No
   If yes, provide details: _____
   _____

6. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s) _____
   _____

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