STROKE/TIA QUESTIONNAIRE

DATE:_____ ADVISOR NAME: _____
PHONE:_____ FAX:_____ EMAIL:_____

CLIENT INFORMATION:

PROPOSED INSURED:_____ DATE OF BIRTH:____/____/____

☐ MALE ☐ FEMALE STATE OF SALE:_____ HEIGHT:_____ WEIGHT:_____

TOBACCO USE: ☐ YES ☐ NO ☐ QUIT WHEN_____

OTHER COMPANY ACTIONS: ☐ RATED TABLE____ ☐ POSTPONED ☐ DECLINED

OTHER COMPANY DETAILS:_____

DATE OF FIRST STROKE:____/____/____ DATE OF LAST STROKE:____/____/____

NUMBER OF STROKES WITHIN THE LAST 24 MONTHS:_____ APPROXIMATE DATE OF LAST EKG:____/____/____

LAST CHOLESTEROL READING:_____ LAST BLOOD PRESSURE READING:_____/_____

HAS PROPOSED INSURED EVER HAD A TIA (TRANSIENT ISCHEMIC ATTACK)? ☐ NO ☐ YES

DOES PROPOSED INSURED HAVE ANY OF THE FOLLOWING RESIDUAL NEUROLOGICAL DEFICITS?
☐ SLURRED SPEACH ☐ LOSS OF USE OF LIMB ☐ RESTRICTED USE OF LIMB ☐ OTHER:_____

HAS THE PROPOSED INSURED HAD A COROTID ARTERY SURGERY AS A RESULT OF A STROKE? ☐ NO ☐ YES - YEAR:_____

DOES PROPOSED INSURED REGULARLY EXERCISE THREE OR MORE TIMES PER WEEK?
☐ NO ☐ YES - PLEASE PROVIDE DETAILS:_____

PLEASE LIST ANY OTHER ILLNESS OR IMPAIRMENT:_____
_____

PLEASE LIST ANY MEDICATIONS BEING TAKEN AND THEIR DOSAGE:_____
_____

HAS EITHER PARENT OR ANY SIBLING DIED BEFORE AGE 65, OTHER THAN BY ACCIDENT? ☐ NO ☐ YES

IS PROPOSED INSURED CURRENTLY EMPLOYED OR CAPABLE OF BEING EMPLOYED? ☐ NO ☐ YES

ADDITIONAL COMMENTS:_____
_____
_____

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