



An insurance Designers member since 1986

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. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N

If Yes, please provide details: _____

When did you last use any form of tobacco: ____ (Month) ____ (Year) Type used last: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

(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:
