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MEDICAL HISTORY QUESTIONNAIRE: STROKE/TIA

Client Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Tobacco Usage:

☐ Never
☐ Former Date Stopped: _____
☐ Current Type: _____

Coverage Information:

Type: ☐ Term ☐ UL ☐ IUL ☐ WL ☐ VUL ☐ Survivorship

Face Amount: _____

Premium Tolerance: _____

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of the episode(s)? _____
2. Were any of the following studies completed?
   - ☐ Carotid Ultrasound Date: _____
   - ☐ Head CT or MRI Date: _____
   - ☐ Echocardiogram Date: _____
3. Was the client hospitalized? ☐ No ☐ Yes; please provide details _____
4. When did the client last see their doctor for evaluation? _____
5. Please check any of the following that your client has had:
   ☐ Coronary Artery Disease ☐ Diabetes ☐ Elevated Cholesterol ☐ Heart Attack
   ☐ High Blood Pressure ☐ Peripheral Vascular Disease ☐ Stroke
6. Has surgery ever been done on any carotid artery(ies)? No Yes; please provide details
7. Give the date and results of the most recent blood pressure readings:
   Date: Results:
8. Are there any residuals (limitation of movement, speech or vision)? ☐ No ☐ Yes; please provide details
9. Please list current medications (including inhalers):

Name of Medication	Dosage	Reason

10. Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes

If yes, please provide details: _____