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. cigars, pipe, snuff, nicotine patch, 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:

_____

_____

_____

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