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: _____