Stroke / TIA Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information

1	What is/are the date(s) of the episode		When did the client last see their doctor for evaluation?
2	Were any of the following studies completed?	☐ carotid ultrasound	*date*
		☐ head CT scan or MRI scan	*date*
		☐ echocardiogram	*date*
3	Has client been hospitalized for treatment	☐ Yes ☐ No	*If yes, give details, dates and lengths of stay*
4	List current medications (accurate name, dosage and reason)		
5	Please check any of the following that your client has had	☐ elevated cholesterol	☐ heart attack / ☐ stroke
		☐ diabetes	☐ coronary artery disease
		☐ high blood pressure	☐ peripheral vascular disease
6	Has surgery ever been done on any carotid arteries	☐ Yes ☐ No	*If yes, give details*
7	Date and result of most recent blood pressure reading		
8.	Aer there any residuals (limitation of movement, speech or vision?)	☐ Yes ☐ No	*If yes, give details*
9	Does the client have any other health issues	☐ Yes ☐ No	If yes provide details:

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