

# STROKE, TIA

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

## FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
**If yes, use separate sheet to provide this information, including age of onset and date of death**

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date(s) of the episode(s)? \_\_\_\_\_

2. Were any of the following studies completed?

- Carotid ultrasound Date: \_\_\_\_\_
- Head CT scan or MRI scan Date: \_\_\_\_\_
- Echocardiogram Date: \_\_\_\_\_

3. Was client hospitalized  No  Yes; please give details

\_\_\_\_\_

4. When did client last see their doctor for evaluation? \_\_\_\_\_

5. Please check any of the of the following that your client has had:

- elevated cholesterol  Stroke  diabetes  heart attack
- high blood pressure  peripheral vascular disease  coronary artery disease

6. Has surgery ever been done on any carotid artery(ies)?  No  Yes; please give details

\_\_\_\_\_

7. Give the date and result of the most recent blood pressure readings: Date: \_\_\_\_\_

8. Are there any residuals (limitation of movement, speech, or vision)?  No  Yes; please give details

\_\_\_\_\_

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

10. Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details

\_\_\_\_\_

