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: _____

_____

_____

_____