



MEDICAL HISTORY QUESTIONNAIRE: STROKE/TIA

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage: Never Former Current
 Date Stopped: _____ 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: _____