



STROKE/TIA QUESTIONNAIRE

Name: _____ Date of Birth: _____

Height _____ Weight _____ Cigarette Smoker: Yes No Quantity per day: _____

Occupation: _____

1. Number of strokes / TIA's: _____
2. Date(s) of stroke / TIA (month & year) _____
3. Cause of stroke / TIA (if known): _____
4. Do you have any residual neurological deficits?
 - Slurred speech
 - Arm or leg weakness
 - Memory impairment
 - Other _____
5. Have you ever had carotid artery surgery?
 - Yes No If yes, date(s): _____
6. Last cholesterol reading (if known): _____
7. Last blood pressure reading (if known): _____ / _____
8. List all medications currently being taken: _____

9. List any other illness or impairment: _____

Name of physician with stroke / TIA records: _____

Address: _____

Notes/comments: _____

Agent: _____

Address: _____

Phone: _____ Fax: _____

Signature of Proposed Insured: _____ Date: _____