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 ☐ Disability **Coverage Amount:** _____

Annual Income:_____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by 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)? _____ Was it diagnosed as: ____ Stroke ____Transient Ischemic Attack (TIA)

Type of episode: ___ Ischemic (e.g. clot/embolism) ___ Hemorrhagic (i.e., brain bleed)

2. Were any of the following studies completed?

☐ Carotid ultrasound Date: _____ Results: _____

☐ Head CT scan or MRI scan Date: _____ Results: _____

☐ Echocardiogram Date: _____ Results: _____

3. Was client hospitalized ☐ No ☐ Yes; please give details_____

4. Was a cause identified? __No __ Yes; please give details_____

If due to an atrial septal defect (ASD, PFO), was this corrected? ___No ___ Yes; Date: _____

5. When did client last see their doctor for evaluation? _____

6. 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

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

_____

8. Give the date and result of the most recent blood pressure readings: Date: _____ _____

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

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

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