

STROKE (Cerebrovascular Accident) QUESTIONNAIRE

CLIENT: NAME _____ / M F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED \$ _____ / MAX. ANNUAL PREMIUM \$ _____ / TYPE OF INS. UL TERM YRS. LVL _____

TOBACCO USE NO YES, TYPE _____ / REPLACEMENT YES NO / CURRENT ANN. PREM. \$ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH _____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? NO YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____ / _____ / ARE YOU TREATED FOR BLOOD PRESSURE NO YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL NO YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. PLEASE LIST DATE OF CLIENT'S FIRST STROKE:

MONTH _____ YEAR _____

2. PLEASE LIST DATE OF CLIENT'S LAST STROKE:

MONTH _____ YEAR _____

3. PLEASE NOTE NUMBER OF STROKES SUFFERED DURING THE PAST 24 MONTHS:

- NONE
- ONE
- TWO
- THREE

4. HAS CLIENT EVER HAD CAROTID ARTERY SURGERY AS THE RESULT OF A STROKE?

NO YES, DATE: MONTH _____ YEAR _____

5. AS A RESULT OF STROKE, DOES CLIENT HAVE ANY RESIDUAL NEUROLOGICAL DEFICITS?

- NONE
- SLURRED SPEECH
- LOSS OF USE, OR RESTRICTED LIMB MOVEMENT
- OTHER IMPAIRMENT: _____

6. APPROXIMATE DATE OF THE LAST STRESS EKG:

- WITHIN THE LAST 6 MONTHS
- 6 MONTHS TO A YEAR AGO
- MORE THAN A YEAR AGO

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY):

