Stroke (CVA)/Mini Stroke (TIA)

Questionnaire

Knowledge. Experience. Results.

Please answer all questions applicable to the client's medical history.

Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____ ☐ Male ☐ Female

Face Amount _____ Max Premium $ _____ /yr. ☐ Term ☐ Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency _____ Date of last use _____ Type _____

☐ Stroke ☐ Mini stroke (TIA) Date _____

What follow-up studies were done following the stroke/mini stroke (select all that apply)

☐ CT scan ☐ MRI scan ☐ Carotid ultrasound ☐ Echocardiogram ☐ Other _____

Select the following conditions the client has been diagnosed with

- ☐ Hypertension; Current reading _____
- ☐ Elevated cholesterol; Most recent reading _____
- ☐ Heart attack (MI); Date(s) _____
- ☐ Diabetes; Date of diagnosis _____ Treatment _____ Most recent A1C result _____
- ☐ Coronary artery disease; Date of diagnosis; Details _____
- ☐ Peripheral vascular disease; Date of diagnosis; Details _____
- ☐ Valve disorders; Date of diagnosis; Details _____
- ☐ Cardiomyopathy; Date of diagnosis; Details _____
- ☐ Atrial fibrillation; Date of diagnosis; Details _____

Describe any symptoms experienced at the time of the stroke/mini stroke

Describe any residual neurologic deficits or other residual effects fro the stroke/mini stroke

Any changes in ADLs (Activities of Daily Living) ☐ Yes ☐ No (if yes, describe below) On disability? ☐ Yes ☐ No

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has:

Questions? Call Jim or Teresa at 877.564.1707.
Please email the completed form to jrmosel@moseleymcgill.com.

Moseley McGill BROKERAGE