



**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: \_\_\_\_\_