

Stroke, Cerebral Vascular Accident (CVA) or Transient Ischemic Attack (TIA) Questionnaire

Name Male Female Age _____ Date of Birth _____

Tobacco Use No Cigarettes Other tobacco _____ Date quit? _____

State _____ Amount of Insurance _____ Type of Insurance _____

Occupation/Source of income: _____

Stroke or Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA)

1. Date (s) of Stroke (s): _____

- Do you have any physical or neurological residuals: No Yes- Details: _____

2. Date (s) of TIA (s): _____

- Do you have any physical or neurological residuals: No Yes- Details: _____

3. List all medications (including aspirin): _____

4. Test Results: Resting EKG – Normal Abnormal, Stress EKG Normal Abnormal, Echocardiogram Normal Abnormal, Carotid Ultrasound Normal Abnormal, Head CT scan and MRI Normal Abnormal.

5. Do you have any of the following complications: coronary artery disease, cardiac arrhythmia or irregular heart beat, CHF or congestive heart failure, heart murmur, diabetes, kidney disease, hypertension, peripheral vascular disease (PVD), family history of coronary disease or strokes?

Details #5: _____

6. How often do you visit your physician? _____

General Questions:

1. Do you have any other major health problems? No Yes – Details: _____

2. List all medications: _____

3. Height: _____ Weight: _____ Most recent blood pressure reading: _____

Agent Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____