U.S. FINANCIAL LIFE Insurance Co.

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: _____

PO BOX 1419, Charlotte NC 28201-1419, 800-959-3894