Cerebrovascular Accident (Stroke)

Name _____ **Sex M F** **Date of Birth** _____

Height _____ **Weight** _____ **Smoker? Y N** **State** _____

Coverage Desired? _____ **Amount** _____ **Plan Desired?** _____

Have you ever been Rated or Declined for insurance? If YES Complete details please

_____

Have you ever had a Cerebrovascular Accident or Stroke? Y N
If YES, Complete details and dates please _____

Date of onset of condition, duration, severity, location? _____
Was it associated with exercise, exertion, excitement, any other circumstance? _____
If more than one attack, give frequency, duration, and date of last attack _____
Has treatment been completed? If YES, When? _____

Do you have any current Neurological Residuals from the Stroke(s) Y N
Please describe completely _____

Have you ever had any of the following:
Coronary Artery Disease Y N **Atrial Fibrillation Y N** **Heart Murmer Y N**
Heart Attack Y N **Peripheral Vascular Disease Y N** **Carotid Artery Disease Y N**

Have you had: Carotid Ultrasound Studies? Y N Head CT or MRI Scan? Y N Echocardiogram Y N
Dates and Results? _____

Have you had a Treadmill EKG or any type of Stress Test? If so, When? _____
Were the results normal? _____

What have been your recent Blood Pressure readings? _____
What has been your recent Cholesterol readings? _____

Do you have Diabetes? Y N When Diagnosed? _____
If YES, what medication are you taking? _____

Do you have any Family History of Heart Disease or Diabetes? _____
_____

Please list all medications being taken: _____
_____

Do you have any other major health problems? (example: cancer, etc)?
_____

Please also submit a copy of any recent Catheterizations or Stress Tests

Broker Submitting Questionnaire: _____
Address _____
Phone: _____ **FAX:** _____ **E-mail:** _____

Please send completed form: **Victorson Associates, Inc. PO Box 863 Smithtown, NY 11787**
You may Fax to: (631) 265-7054 or E-mail to: vainc@victorson.com