MADISON™ BROKERAGE
The Advisor's Advisor
ACRISURE® PARTNER

STROKE (CVA) / MINI STROKE (TIA) QUESTIONNAIRE

Agent: ______________________ **Phone:** ______________________ **Fax:** ______________________

Proposed Insured Name: ____________ **(M or F):** ________ **Age**: ________

Face Amount: ____________ Max Premium $: ________ / year Type: **(UL, WL, Term, or Survivorship)** ______________________

Do you currently smoke cigarettes? **(Y or N):** ______ If no, did you ever smoke: **(Y or N):** ______ Quit date: ______________

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...):

If Yes, please provide details: ____

When did you last use any form of tobacco: (Month) ______ (Year) ______ Type used last: ______________________

Date(s) of Stroke(s) (CVAs) or Mini Strokes (TIAs): ____

What follow up studies were done following the reported Stroke (CVA) or Mini Stroke (TIA)? **Y or leave blank...**

CT Scan ______ Carotid Ultrasound ______ MRI Scan ______ Echocardiogram ______ Other ______

Is the proposed insured taking any medications?

Name of Medication (Prescribed or OTC)	Dates Used	Quantity Taken	Frequency

Has the proposed insured been diagnosed with any following conditions: Date of diagnosis & details:

Hypertension? What is the most current reading? ____

Elevated Cholesterol? What is the most recent reading? ____

Heart attack (MI)? Date: ____

Diabetes? Date of diagnosis: ____________ How controlled? ____________ Most recent A1C test result? ____________

Coronary Atery Disease (CAD)? Date of diagnosis and 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 (CVA) or Mini Stroke (TIA)? ____

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Describe any residual neurologic deficits or other residual effects from the Stroke (CVA)? ____

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Does the proposed insured have any other medical conditions? If yes, please describe: ____

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