



# STROKE

## PRELIMINARY UNDERWRITING QUESTIONNAIRE

Client:

Gender: M F DOB:  
Height: Weight:

Coverage Desired?

Amount?

Plan Desired?

If your client has ever had a Stroke, please answer the following:

### STROKE HISTORY

- 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? Y N *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? *Please select all that apply*  

Coronary Artery Disease	Atrial Fibrillation	Heart Murmur
Heart Attack	Peripheral Vascular Disease	Carotid Artery Disease
- Have you had: *Please select all that apply*  

Carotid Ultrasound Studies	Head CT or MRI Scan	Echocardiogram
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*Dates and results?*
- Have you had a Treadmill EKG or any type of Stress Test? Y N  
*If so, when? Were the results normal?*

### CURRENT STATE

- Please list current medications:
- What have been your recent Blood Pressure readings?
- What have been your recent Cholesterol readings?
- Do you have Diabetes? Yes No When diagnosed?  
*If Yes, what medication are you taking?*
- Do you have any Family History of Heart Disease or Diabetes?
- Do you have any other major health problems (ex: heart disease, etc.)? Yes No  
*If yes, please give details:*

### ADDITIONAL COMMENTS

Do you have any additional comments?

Advisor:

Date:

For more information, contact:  
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