



CEREBRAL VASCULAR and NEUROLOGICAL QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
Broker's Name: _____ Face Amount: _____
Address: _____ Phone: _____ Fax: _____

Proposed Insured please answer the following:

1. Indicate what you have been diagnosed with:

- | | |
|--|---|
| <input type="checkbox"/> Amnesia | <input type="checkbox"/> Stroke (Cerebral Vascular Accident / CVA) |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Transient Ischemic Attack (TIA or "mini-stroke") |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Organic Brain Syndrome |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Other: | |

2. Please give date(s) of diagnosis and occurrence(s):

Date: _____ Details: _____

Date: _____ Details: _____

Date: _____ Details: _____

3. Have any special tests or studies been done (i.e. CAT scan, MRI, Stress Test)?

No Yes, Details: _____

4. Have or do you require assistance on a regular basis? No Yes, Details: _____

5. Are you fully recovered? No Yes, Details: _____

6. Do you have any other major health problems?

7. Are you on any medication(s)? No Yes, Name(s) and dosage(s): _____
