RESET

STROKE, TIA

AGENT NAME: _____

CLIENT NAME: _____ **Date:** _____

1. Date(s) of the episode(s)? _____

2. Were any of the following studies completed?

☐ Carotid ultrasound Date: _____

☐ Head CT scan or MRI scan Date: _____

☐ Echocardiogram Date: _____

3. Was client hospitalized ☐ No ☐ Yes; please give details

_____

4. When did client last see their doctor for evaluation? _____

5. Please check any of the of the following that your client has had:

☐ elevated cholesterol ☐ Stroke ☐ diabetes ☐ heart attack
☐ high blood pressure ☐ peripheral vascular disease ☐ coronary artery disease

6. Has surgery ever been done on any carotid artery(ies)? ☐ No ☐ Yes; please give details

_____

7. Give the date and result of the most recent blood pressure readings: Date: _____ _____

8. Are there any residuals (limitation of movement, speech, or vision)? ☐ No ☐ Yes; please give details

_____

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

10. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

Save and Email Completed Form to: quotes@levelfourinsurance.com