Return to - jim@uswolfe.com or Fax to 815-377-3556

# CEREBRAL VASCULAR and NEUROLOGICAL QUESTIONNAIRE

Insured's Name: DOB: State: Sex: M / F

Height: Ft. In. Weight: Face Amount:

Tobacco use in the past 5 years: No Yes Details:

Producer: State: Phone: E-mail:

Proposed Insured please answer the following:

1. Indicate what you have been diagnosed with (circle all that apply):
   - Amnesia
   - Stroke (Cerebral Vascular Accident / CVA)
   - Tremor
   - Transient Ischemic Attack (TIA or "mini-stroke")
   - Parkinson's Disease
   - Organic Brain Syndrome
   - Dementia
   - Alzheimer's Disease
   - 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? No Yes
   Details:

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

8. Name and address of your physician(s) and date(s) last consulted:

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____