

CEREBRAL VASCULAR QUESTIONNAIRE

Please fax back to IPA at 781 643-2775

Name: _____ DOB: _____

1. Have you ever noticed any lightheadedness or near fainting episodes? _____

2. Have you ever had any memory loss or near memory loss, if so, please explain? _____

3. Are you a smoker? _____
4. Have you ever had any diagnostic studies performed for your cerebrovascular area, if so, what was the study and when did it take place?

5. Do you have any other impairments that may have caused your cerebral accident (ie: blood pressure, diabetes, heart)? _____

6. Who is your physician? _____

7. Were you ever told that you had a stroke or TIA? _____
8. Have you ever had any more than one (1) event? _____
9. Have you ever had any surgeries for blood clots, and so on? _____
10. Have your ever had/have any residuals from any of the events noted above, if so, what are they? _____

11. Are you able to work, take care of your self independently, take care of your finances, drive and so on? _____

Agent Name: _____

Phone Number: _____ Fax No: _____

Date: _____ E-mail Address: _____

Please circle the associate you work with. Russ, Rhonda, Leo