TIA/Stroke Questionnaire

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Today's Date: Agent:

Full Name: Male or Female?

Height and weight: Date of Birth:

1. Date of TIA / Stroke (circle one): ____________________

2. Were any of the following studies completed?
   __ carotid ultrasound Date:_______________
   __ head CT scan or MRI scan Date:_______________
   __ echocardiogram Date:_______________

   What were the results? If you are able to get a copy of this test from your doctor's office, this will help us determine the most accurate quote. Or your doctor's office can read the exact results over the phone with you. Please record answer here:
   ____
   ____
   ____

3. What medication do you take, reason, dosage and how often?

4. Were you hospitalized? ____ Yes ____ No (If yes, dates:_______________)

5. When did you last see your doctor for evaluation and what was the outcome? Any further testing recommended?

6. Have you ever had any of the following:
   __elevated cholesterol __stroke
   __diabetes __heart attack
   __high blood pressure __peripheral vascular disease
   __coronary artery disease

7. Has surgery ever been done on any carotid artery(ies)? ____ Yes ____ No
   If yes, please give details ____
   ____

8. Give the date and result of the most recent blood pressure readings:

9. Are there any residuals (limitation of movement, speech, or vision)? Give full details.

10. Please indicate type of tobacco EVER used:

Type:	Amount per (circle frequency):	Date last used:	Still use?
____Smokeless	____daily/monthly/yearly	____________	__Yes __ No
____Cigarettes	____per day/month/year	____________	__Yes __ No
____Cigar	____per day/month/year	____________	__Yes __ No
____Patch/Gum	____per day/month/year	____________	__Yes __ No