Oberlin Marketing
Supporting the direction of your business

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Life Insurance

Stroke Questionnaire

Agent _____

Email _____

Phone ( ) _____-_____

Fax ( ) _____-_____

Client _____

❑ **Male** ❑ **Female** **DOB** _____

❑ **Non-Tobacco** ❑ **Tobacco**

❑ Never ❑ Cigarettes _____ per day

❑ Quit _____ ❑ Cigar _____ per week

❑ Pipe _____ per week

State_____ ❑ Chew _____ per week

Height _____

Weight _____ **U S Citizen** ❑ Yes ❑ No

Death Benefit $_____

Plan ❑ Term 5 10 15 20 25 30

❑ Universal Life ❑ Option 1 ❑ Option 2

❑ Whole Life ❑ Par ❑ Non-Par

❑ 2nd to Die

❑ Simplified

❑ Guaranteed

Has client been ❑ Rated _____ ❑ Declined

Company _____

1 Date of first stroke _____

2 Other strokes

Date _____

Date _____

Date _____

3 Date of last symptoms _____

4 Carotid Artery surgery

Date _____

5 Carotid Artery Ultrasound

Date _____

Result _____

6 Any residual problems

❑ Loss of use of limb

❑ Restricted use of limb

❑ Restriction of mobility

❑ Slurred Speach

❑ Vision

❑ Weakness

❑ Other impairment _____

7 Date of last stress EKG _____

8 Type of exercise_____

Frequency _____

9 List any other illness or impairment in notes.

Complete appropriate questionnaire if necessary.

Blood Pressure_____**Cholesterol**_____

Current meds, dosage & reason

_____

_____

_____

_____

_____

Do any of these activities apply?

❑ Aviation ❑ Racing

❑ Foreign Travel ❑ Scuba/Skin Diving

❑ Mountain Climbing ❑ Sky Diving

If yes, will need a questionnaire completed with details.

Moving Violations or DUI last 5 yrs

Date _____ Type _____

Date _____ Type _____

Date _____ Type _____

Family History - Cancer or Heart death or diagnosis in parents or siblings - who-what-when

_____

_____

_____

_____

Notes:_____

_____

_____

_____

_____

_____

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