

CEREBRAL VASCULAR and NEUROLOGICAL QUESTIONNAIRE

Rohrer & Associates

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: _____