National Life Insurance Company®
Life Insurance Company of the Southwest™

Stroke / Transient Ischemic Attack (TIA) Questionnaire

Name *(please print)*: Date of Birth: Policy #: Date Completed:

What was cause of the stroke / TIA?

Date of all episodes: *[please indicate if these were transient ischemic attacks (TIAs) or strokes]*

What were your symptoms?: *(i.e. coma, paralysis, seizure, difficulty speaking, headache, dizziness, etc.)*

What parts of the body were affected?

Do you have any residual paralysis, disabilities or restrictions? *(If yes, please provide details)* ☐ Yes ☐ No

Have you had any further symptoms since your stroke or transient ischemic attack (TIA)?

What medication(s) are you currently taking and the dosage(s)?

Was any surgery, testing or other treatment needed? *(If yes, please provide details)* ☐ Yes ☐ No

Physician's Name	Address/Telephone Number	Date Last Seen/Frequency	Area of Specialty *(i.e. family physician, neurologist, other)*

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