

CVA/TIA

Client's Name _____

If your client has had a Cerebral Vascular Accident or Transient Ischemic Attack, please answer the following:

1. Please list date(s) of the CVA(s) or TIA(s) _____
2. Where any of the following studies completed?
 carotid ultrasound _____ (date)
 head CT scan or MRI scan _____ (date)
 echocardiogram _____ (date)
3. Is your client on any medications?
 yes, please give details _____
 no
4. Please check if your client has had any of the following:
 elevated cholesterol stroke
 diabetes heart attack
 high blood pressure peripheral vascular disease
 coronary artery disease
5. Has your client smoked cigarettes in the last 12 months? yes no
6. Has surgery ever been done on the carotid artery (ies)?
 yes, please give details _____
 no
7. Please give the date and result of the most recent blood pressure reading _____
8. Does your client have any other major health problems (example: Cancer, etc.)?
 yes, please give details _____
 no

Agents name:

Agents Tell #

Agent Fax #

Date Submitted:

Agents e-mail address:

PLEASE FAX TO BEST MARKETING AT 1-781 643-2775