

MEDICAL HISTORY QUESTIONNAIRE: MULTIPLE SCLEROSIS

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage: Never Former Current Date Stopped: _____ Type: _____

Coverage Information: Type: Term WL UL VUL IUL Survivorship
 Face Amount: _____ Premium Tolerance: _____

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. List the date of first diagnosis: _____

2. Indicate number of episodes: _____

3. Date of last episode: _____

4. Please note current neurological status and/or symptoms:

- Normal
- Minimal residual impairment (specify) _____
- Moderate residual impairment (specify) _____
- Severe residual impairment (specify): _____

5. What are the client's current symptoms? _____

6. What therapy is the client on? _____

7. Does client have any problems with extremities, kidneys or bladder? No Yes

If Yes, please provide details: _____

8. Please list current medications:

Name of Medication	Dosage	Reason

9. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details: _____