MEDICAL HISTORY QUESTIONNAIRE: MULTIPLE SCLEROSIS

Client Name: _____ Date of Birth: _____

Gender: ☐Male ☐Female Height: _____ Weight: _____

Tobacco Usage:

☐Never

☐Former Date Stopped: _____

☐Current Type: _____

Coverage Information:

Type: ☐Term ☐UL ☐IUL

☐WL ☐VUL ☐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 syptoms? _____

_____

_____

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: _____

_____

_____

_____