

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 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: _____