



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)

- List the date of first diagnosis: _____
- Indicate number of episodes: _____
- Date of last episode: _____
- Please note current neurological status and/or symptoms:
 - Normal
 - Minimal residual impairment (specify) _____
 - Moderate residual impairment (specify) _____
 - Severe residual impairment (specify): _____
- 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: _____