

## 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  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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_