

# Multiple Sclerosis Questionnaire



Submit This Form with your application for better informed underwriting

## Client Information

<b>Client Name:</b>					
<b>DOB:</b>	<b>Gender</b>	<b>Height</b>	<b>Weight</b>	<b>Marital Status</b>	
<b>Occupation &amp; Length of Employment:</b>					
<b>Tobacco Use</b>	Never Used	Totally Stopped		Current User	
		<b>Date Stopped</b>		<b>Type Used</b>	
<b>Type of Coverage</b>	Term	UL	Survivor	<b>Amount \$</b>	

## Essential Information

1	Date of first Diagnosis			Number of Episodes
				Date of last Episode
2	Please note current neurological status and/or symptoms			
	<input type="checkbox"/> Normal			
	<input type="checkbox"/> Minimal residual impairment (please specify )			
	<input type="checkbox"/> Moderate residual impairment (please specify)			
3	List current medications (accurate name, dosage and reason)			
4	What are client's current symptoms?			
5	Does client have any problems with extremities, kidneys, or bladder?	<input type="checkbox"/> Yes	<i>If yes, give details</i>	
		<input type="checkbox"/> No		
6	What therapy is client on?			
7	Does the client have any other health issues	<input type="checkbox"/> Yes	If yes provide details:	
		<input type="checkbox"/> No		