

Life Scan Questionnaire for **MULTIPLE SCLEROSIS**
LIFE INSURANCE RISK EVALUATION AND MARKET SEARCH

For _____ [] Male [] Female
 Date of Birth _____ Age _____ State _____
 Height _____ Weight _____ [] Non Smoker [] Smoker
 Have you ever used tobacco? [] Yes [] No If Yes, state month
 and year of last use of any tobacco product: _____
 Type of tobacco used [] Cigarettes [] Cigars [] Chews [] Pipe
 Amt \$ _____ Type [] Whole Life, Variable or Universal [] Term
 Last application for life insurance: Year _____ Company _____
 Result : [] Preferred [] Standard [] Rated/Rating _____ [] Declined
[] Life Insurance Risk Evaluation and Market Search for Best Offer
[] Risk Evaluation Only

1. PLEASE LIST DATE OF DIAGNOSIS _____
2. IS MULTIPLE SCLEROSIS ACTIVE: [] NO [] YES
 DATE OF LAST ATTACK _____
3. PLEASE LIST CURRENT MEDICATION(S) TAKEN AND DOSAGE(S) FOR MS:

4. WHAT IS THE DEGREE OF SEVERITY OF MS?
 [] MILD – TOTAL OF 2 TO 4 MILD EXACERBATIONS WITH NO RESIDUALS
 [] MODERATE – SLOWLY PROGRESSIVE, ONE OR TWO ATTACKS PER YEAR WITH
 RECOVERY BETWEEN ATTACKS AND SOME MODERATE RESIDUALS SUCH AS CANE USE
 [] SEVERE – PROGRESSIVE, MORE THAN 2 ATTACKS PER YEAR, WHEEL CHAIR
 CONFINEMENT, BEDRIDDEN
 [] RAPIDLY PROGRESSING SYMPTOMS
5. CURRENT SYMPTOMS (CHECK ALL THAT HAVE OCCURRED OVER THE PAST TWO YEARS):
 [] VISUAL DIFFICULTIES
 [] NUMBNESS
 [] WEAKNESS OR FATIGUE
 [] IMPAIRED SWALLOWING
 [] FREQUENT BLADDER INFECTIONS
 [] BOWEL CONTROL DIFFICULTIES
 [] USE OF CANE
 [] USE OF WHEEL CHAIR
 [] DIFFICULTY WITH SPEECH
6. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:
 [] 0 TO 6 MONTHS AGO
 [] 6 TO 12 MONTHS AGO
 [] 12 TO 24 MONTHS AGO
 [] OVER 2 YEARS AGO
7. LIST ANY OTHER ILLNESSES OR IMPAIREMENTS (COMPLETE ANY OTHER QUICK QUOTE
 ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY):

Life Factors
Date of last stress EKG
 Month ____ Year ____ [] Never

Family History, has either
 parent or any sibling died
 before age 65?

[] Yes [] No If yes, please
 list cause and age.

Blood Pressure, with or without
 medication _____ / _____
 List medication, if any

Result of last **Cholesterol** test,
 if known _____

List all **Other Illnesses** not
 listed on this page.

List all medications currently
 being used except those
 previously listed.
 (name, dosage and times per day)

Agent Information

Name _____
 Address _____
 City _____
 ST _____ Zip _____ email _____
 Phone _____

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