Multiple Sclerosis Questionnaire

Name: ____________________________ Date of Birth: _________________________

Height: _________ Weight: _________ Sex: M/F

Tobacco Usage: ___________________ Face Amount: ______________________

___Term 10 15 20 30 ___UL

1. When was the proposed insured first diagnosed with Multiple Sclerosis?

____

2. Which form, of Multiple Sclerosis, is diagnosed? (Check one)
___Relapsing-remitting MS ___Secondary Progressive MS

3. Does the proposed insured suffer from any of the following? (Check all that apply)
___Muscle Symptoms (weakness, stiffness, clumsiness, ataxia)
___Visual Symptoms (blurred, foggy or hazy vision, eye pain, optic neuritis)
___Sensory symptoms (tingling, numbness, tightness in the trunk or limbs)
___Bladder Symptoms (urinary incontinence, loss of bladder sensation)
___Cognitive symptoms (memory loss, difficulty concentrating, reduced attention span, difficulty finding correct words)
___Depression and/or anxiety
___Vertigo ___Tremor ___Pain ___Constipation

4. Is, the proposed insured, disabled as a result of this condition? _____Yes _____No
(If yes, provide details) ____
____
____

5. Is the proposed insured taking any medication? _____Yes _____No
(If yes, please provide name, dosage, and frequency)
____
____
____
____

BSI (800) 229-9020 Local (301) 540-8484 Fax (301) 540-8787