Tourette's Syndrome Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 __UL

1. Please provide the date of diagnosis: _____

2. Does the proposed insured experience any of the following? (Please check all that apply)

___Simple motor tics involving only one muscle group
___Complex motor tics involving a series of movements or muscle groups
___Simple vocal tics involving simple sounds
___Complex vocal tics involving words, phrases and sentences

3. Has the proposed insured ever suffered from any of the following: (Check all that apply)

____Depression Dates: _____
Details: _____

___Attention deficit disorder: Dates: _____
Details: _____

___Obsessive compulsive disorder Dates: _____
Details: _____

4. How is the Proposed Insured being treated?

_____
_____

5. Is the Proposed Insured disabled as a result of this condition? ___Yes ___No

6. Please provide the name, dosage, and frequency of all medications:

_____
_____
_____
_____

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