

# MULTIPLE SCLEROSIS QUESTIONNAIRE

Rohrer & Associates

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ State: \_\_\_\_\_ Sex: M / F  
Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In. \_\_\_\_\_ Weight: \_\_\_\_\_ Face Amount: \_\_\_\_\_  
Tobacco use in the past 5 years: No Yes Details: \_\_\_\_\_  
Producer: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Proposed Insured please answer the following:

1. Please list date of first diagnosis: \_\_\_\_\_
  
2. Please indicate the number of episodes and date of last episode: \_\_\_\_\_
  
3. Are you on any medication(s)? Yes No  
Name(s) and dosage(s): \_\_\_\_\_
  
4. Please note your current neurologic status and/or symptoms (please circle):  
normal  
minimal residual impairment (please specify): \_\_\_\_\_  
moderate residual impairment (please specify): \_\_\_\_\_  
severe residual impairment (please specify): \_\_\_\_\_
  
5. Do you have any other major health problems (i.e. heart disease, etc.)? Yes No  
Details: \_\_\_\_\_
  
6. List name, address & phone number of any doctor(s) and the date last consulted: \_\_\_\_\_

---

Additional Information (please use reverse side for additional space):

Date: \_\_\_\_\_ Insured's Signature: \_\_\_\_\_