

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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