

**Multiple Sclerosis (MS) Questionnaire**

Name  Male  Female Age Date of Birth

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Tobacco Use  No  Cigarettes  Other tobacco Date quit?

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State Amount of Insurance Type of Insurance

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Occupation/Source of income:

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1. Date Multiple Sclerosis diagnosed? Age at diagnosis?

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2. Number of episodes? Date of last episode?

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3. Current functional stage of Multiple Sclerosis?

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- No symptoms or residual
- Mild symptoms or residual – Please describe:
- Moderate symptoms or residual – Please describe:
- Severe symptoms or residual –  restricted to wheelchair or  bed

4. Has the MS symptoms been progressing?  No  Yes

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5. Current medications and treatments for MS:

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**General Questions:**

1. Do you have any other major health problems?  No  Yes – Details:

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2. List all medications:

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3. Height Weight Most recent blood pressure reading:

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**Agent Name:**

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**Address:** **City:** **State:** **Zip:**

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**Phone:** **Fax:** **Email:**

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