

Chiari Malformation Questionnaire

Agent Name: _____ Phone #: _____ E-mail: _____
Client Name: _____ Date of Birth: _____ Sex: Male / Female _____
Height: _____ Weight: _____ State: _____ Smoker: Y / N Face Amount: _____
Type of Insurance: Universal Life Whole Life Survivorship Term (# of years _____)

1. When type of Chiari Malformation has been diagnosed?

<input type="checkbox"/> Type 1	Date of diagnosis: _____
<input type="checkbox"/> Type 2	Date of diagnosis: _____
<input type="checkbox"/> Type 3	Date of diagnosis: _____
<input type="checkbox"/> ACM2	Date of diagnosis: _____
<input type="checkbox"/> ACM2	Date of diagnosis: _____
<input type="checkbox"/> ACM3	Date of diagnosis: _____

2. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)

Headache
 Vomiting
 Difficulty swallowing and/or hoarseness
 Dizziness
 Impaired ability to coordinate movement
 Double vision
 Involuntary rapid downward eye movements
 Other: _____

3. Has surgery been done or recommended for this condition? Yes No

If yes, provide details: _____

4. Has the proposed insured ever been disabled as a result of this condition? Yes No

If yes, provide details: _____

5. Is the proposed insured taking any medication(s)? Yes No

If yes, provide name, dosage and frequency of medication(s): _____

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