



# Diversified Marketing Group, Inc.

## HEADACHE QUESTIONNAIRE

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Proposed Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
Tobacco Use:  Yes  No Amount: \_\_\_\_\_ Height: \_\_\_\_\_ Ft. In. Weight: \_\_\_\_\_  
Broker's Name: \_\_\_\_\_ Face Amount: \_\_\_\_\_  
BGA: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Proposed Insured please answer the following:

1. What is your actual diagnosis?
2. When did your headaches first start?
3. When was your last headache?
4. How often do your headaches occur?
5. The duration of your headaches are:  
 Intermittent       Continuous       Brief       Prolonged
6. Which part of your head is usually affected?  
 Front       Back       Top       Sides
7. Are your headaches associated with certain foods such as chocolate, coffee, or MSG?  
 No     Yes, Details: \_\_\_\_\_
8. Indicate below any other associated symptoms:  
 Vision (vision fields or double vision)     Numbness or tingling     Muscle weakness  
 Unsteadiness of limbs or staggering     Nausea, vomiting     Undue sleepiness  
 Dizziness, hearing loss     Kidney disorder     High blood pressure  
 Have fits or explosive behavior
9. Is there any relationship between your headaches and any of the below:  
 Allergies       Medications       Nervous tension       Menstrual cycle
10. Have you had any special diagnostic testing done for your headaches?  
 No     Yes, Details: \_\_\_\_\_
11. Are you on any medication(s) and/or treatment(s)?     No     Yes, Name(s) and dosage(s): \_\_\_\_\_
12. Date you last consulted your physician: \_\_\_\_\_
13. Name and address of your physician(s): \_\_\_\_\_

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Underwriter's Notes:

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