

TIC Financial Services
HEADACHE QUESTIONNAIRE

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

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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Date: _____ Proposed Insured's Signature: _____