310 S. Dale Mabry Hwy, Ste 210
Tampa, FL 33609
Phone (813) 875-6331
Fax (813) 875-7331

Headache Underwriting Questionnaire

Agent Name_____ Phone _____

Email Address _____

Applicant Last Name _____ Date of Birth _____

Sex ☐ Male ☐ Female Height/Weight _____ / _____

Occupation _____ Ever use nicotine products? _____

If yes, select type : ☐Cigarettes ☐ Cigar ☐ Chewing tobacco ☐ Other: _____

Date last used _____ Frequency per month _____

Product Applying for: ☐ Term ☐ Universal Face Amount _____

1. What is your medical diagnosis: _____
2. When did your headaches start: _____ Date of last headache: _____
3. Please describe the frequency and the duration of your headaches: _____
   _____
4. Which part of your head is usually affected: _____
5. Are your headache associated with or triggered by certain foods, such as chocolate, coffee, or MSG? If so, please provide details _____
6. Indicate below any associated symptoms:

☐ Vision impairments (vision field, double vision, "aura") ☐ Numbness or tingling ☐ Muscle weakness
☐ Unsteadiness of limbs or staggering ☐ Nausea or vomiting ☐ Undue sleepiness
☐ Dizziness, hearing loss ☐ Kidney Disorder ☐ High Blood Pressure
☐ Have fits or explosive behavior

7. Is there any association between your headaches and any of the following:

☐ Allergies ☐ Medications ☐ Nervous tension ☐ Menstrual cycle

8. Have you had any diagnostic test performed for your headaches? ☐ No ☐ Yes; details
   _____
9. List medications and treatment:

Name of Medication	Dosage	Reason

1. Please list name of physicians and date last seen:

Name of physician	Location	Date last seen

Please fax this form to MRW Financial Inc. 813-875-7331 or email to marie@mrwfinancial.com