



Chiari Malformation Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/F

Tobacco Usage: _____

Face Amount: _____

State of Residence: _____

___Term 10 15 20 30 ___UL

1. Which type of Chiari Malformation has been diagnosed?

___Chiari Type I

___Chiari Type II

___Chiari Type III

___ACM1

___ACM2

___ACM3

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

___Headache

___Vomiting

___Difficulty swallowing and/or hoarseness

___Dizziness

___Impaired ability to coordinate movement

___Double Vision

___Involuntary rapid downward eye movements

3. Has surgery been done and/or recommended for this condition? ___Yes ___No

(If yes, please provide details): _____

4. Is, the proposed insured, disabled as a result of this condition? ___Yes ___No

5. Is the proposed insured taking any medication? ___Yes ___No

(If yes, please provide the name, dosage, and frequency): _____

