



Spina Bifida Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/F

Tobacco Usage: _____

Face Amount: _____

State of residence _____

___Term 10 15 20 30

___UL

1. When was Spina Bifida diagnosed? _____

2. What type of aneurysm was diagnosed? ___Spina bifida occulta ___Spina bifida manifesta

3. Which of the following symptoms does the proposed insured experience (circle all that apply)?

Dimple Depression Birthmark over affected vertebrae Difficulty walking

Bladder control problems Coordination problems Paralysis in legs

4. How has the Spina bifida been treated?

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

(If yes, please provide the name, dosage, and frequency of all medications) _____
