GENERALI Central
LIFE INSURANCE

Neurological Disorder Questionnaire - Physician

Name of the Life Insured	
Application Number	

1. Which neurological disorder does/did your patient suffer from?

2. When did the symptoms first occur?

3. Please describe the presenting symptoms:

4. If there was more than one episode, please give dates, duration and severity of each episode:

5. When were the last symptoms seen? What was the frequency of the episodes?

6. Please describe the current status of the disorder, including any improvement or worsening of the initial symptoms:

7. Impact of condition:

   a) Is there, or has there been any restriction or limitation on their ability to work? Yes ☐ No ☐

   If 'Yes', please provide details, including duration of any time off- work in the last five years:

   b) Does your patient use a wheelchair or any other form of mobility aid? Yes ☐ No ☐

   If 'Yes', please provide details:

   c) Does your patient require any form of assistance with activities around the house, such as dressing, preparing food, household work or bathing? Yes ☐ No ☐

   If 'Yes', please provide details:

8. Has the patient been referred for specialist opinion or investigation? Yes ☐ No ☐

If 'Yes', please provide full details including name, address and specialty of doctor and dates and nature of any investigations carried out or to be carried out.

If still awaiting an appointment, please advise when do you expect to see the patient:

_____

_____

_____

9. Please provide details of the current treatment, including names and dosages of each medication:

_____

_____

_____

_____

10. If these drugs or dosages have been changed in the last two years, please provide details, including why:

_____

_____

_____

_____

_____

Please state about the patient's reflexes: elbow, wrist, knee, ankle & planter reflexes: _____

Please confirm about tone, power and co-ordination of motor system: _____

Are there any issues with posture and gait? (If yes, please describe): _____ Yes ☐ No ☐

11. Please comment on any other relevant features or co-morbidities or any other illness or habits, which may influence the prognosis of the condition:

_____

_____

_____

_____

_____

Signature: _____

Date: _____

Please print name and add clinic stamp.