Trustmark Insurance Company Medical Questionnaire
PO Box 7930, Lake Forest, IL. 60045
Phone (800) 229-4543 x3413   Fax (847) 615-4954
Migraine Questionnaire

Proposed Insured:
Address:

Home Phone:
Work Phone:

Birthdate:
Employee:
Employer:
Cert.#:

1. Name, address and phone number of your doctor:____________________________________

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2. Date last seen prior to application sign date :__________________________________

3. Current height and weight: ____

4. List all medications you are currently taking: ____________________________________

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5. List all conditions for which you are currently seeing a doctor:__________________________

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6. What is your exact diagnosis?____

7. How frequent do your migraines occur and what is the severity (mild, moderate, severe)?__

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8. Do you know the cause of your migraines? If so, please describe:______________________

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9. Have you had a Cat Scan or a MRI of your head? If yes, give results and dates.__________

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_____________________________ Signature of Proposed Insured

_____________________ Date