



Long Term Care Health Pre-Screening Questionnaire

Agent Name: _____

Client Name and State of Residence: _____

Date of Birth: _____ Height: _____ Weight: _____

Do you use tobacco products? Yes No Type: _____
In past 12 months? Yes No How much? _____

Have you previously been declined for long-term care insurance? Yes No
Reason for decline & Name of Carrier _____

Are you current receiving or have you ever received Worker's Compensation or Disability? Yes No
Reason for the Disability: _____

Type of Disability: _____

Are you actively working? Yes No if no, please describe daily activities _____

List all prescription medications taken over the past 12 months.

1. Medication: _____ Amount: _____ Currently Taking? _____

How Long Taking: _____ Reason Prescribed: _____

2. Medication: _____ Amount: _____ Currently Taking? _____

How Long Taking: _____ Reason Prescribed: _____

3. Medication: _____ Amount: _____ Currently Taking? _____

How Long Taking: _____ Reason Prescribed: _____

4. Medication: _____ Amount: _____ Currently Taking? _____

How Long Taking: _____ Reason Prescribed: _____

Please list any additional medications on the last page.

Do you use a cane, crutches, braces, hospital bed, lift chair, walker, wheelchair, oxygen or kidney dialysis? Yes No

Do you need assistance with: shopping, walking, using transportation, housekeeping, taking medications, or cooking? Yes No

Do you currently need the assistance or supervision of another person in performing any of the following activities: moving in/out of bed or chair, bathing; dressing; toileting; bowel/bladder control or eating? Yes No

Do you have any pending surgeries/test that any doctor has recommended but the test has not yet performed? Yes No
Yes, please provide details _____

Are you currently in Physical therapy or have you had any therapy within the last 6 months? Yes No, if yes, please indicate a date and reason _____

TO BE ABLE TO GIVE YOU ACCURATE INFORMATION IT IS IMPORTANT THAT WE RECEIVE ALL FORMS BACK.

Have you ever been diagnosed by a licensed physician as having any of the following conditions?

(Circle all that apply) Yes No

- | | |
|---------------------------------------|--|
| AIDS/HIV Positive | ALS (Lou Gehrig's Disease) |
| Alzheimer's Disease | Crest |
| Mental Retardation | Cancer , if yes, please provide staging, type of treatment and date of treatment |
| Multiple Myeloma | Cystic Fibrosis |
| Multiple Strokes or TIAs | Muscular Dystrophy |
| Multiple Sclerosis | Neurogenic Bladder |
| Scleroderma | Parkinson's Disease |
| Post Polio Paralytic Syndrome | Dementia/Confusion |
| Spinal Cord Injury | Cerebral Atrophy/Whiter Matter Changes |
| Kidney Failure | Liver Cirrhosis |
| Schizophrenia | Pulmonary Hypertension |
| Urinary incontinence/undergarment use | Memory Loss (Short or Long Term) |

Have you ever received medical advice, diagnosis or treatment for any of the following?

(Circle all that apply) Yes No If yes, please give details on third page

- | | |
|--|-------------------------------------|
| Amputation | Anemia (type) |
| Autoimmune Disorder | Angioplasty/Bypass Surgery |
| Dizziness | Back Disorder/Surgery |
| Arthritis (Gold Steroid /Chronic Steroid/Enbrel) | Epilepsy/Seizures (last occurrence) |
| Blindness/Macular Degeneration | Drug or Alcohol Abuse |
| Falls with Bone Break | Blood Disorder (type) |
| High Blood Pressure | Heart Problems |
| Bronchitis/Asthma | Joint Replacement/Fractures |
| Fibromyalgia/Chronic Fatigue | Cancer |
| Mental/Nervous Disorder | Neurological Disorder |
| COPD/Emphysema | Peripheral Vascular Disease |
| Stress Incontinence | Ulcerative Colitis/Crohn's Disease |
| Depression | Respiratory Disorders |
| Stroke/TIA | Hepatitis (type) |
| Diabetes Mellitus (What type _____ & Insulin units per day _____) | Lupus |
| Elevated PSA or Prostrate Disorders (PSA levels _____) | Sleep Apnea without CPAP Machine |
| Osteoporosis with fractures (Bone density test t-scores _____) | Sleep Apnea with CPAP Machine |
| Aneurysm (type, size, operated or not) | Elevated Liver Enzymes |
| Angioma or Neuroma (operated or unoperated) | |

If you answered "YES" to any of the previous questions, provide full details here.

Diagnosis: _____ Date: _____

Treatments & Dates of Treatment: _____

Prognosis & Date of last treatment: _____

Medications: _____

Diagnosis: _____ Date: _____

Treatments & Dates of Treatment: _____

Prognosis & Date of last treatment: _____

Medications: _____

Give details on any surgery, procedures, or hospitalizations over the last 10 years? (Please explain) (i.e., angioplasty, bypass surgery)

Reason: _____ Date: _____

Treatment or Therapy: _____

Please list additional medications, diagnosis, chronic problems, physical limitations, medical procedures and/or treatments on this page.
(Please provide dates of procedures/treatment)