



A Financial Services Company

Long-Term Care Insurance Health Screening Questionnaire

Client Name: _____

Long-Term Care Insurance is about protecting the things that are important to your clients. When considering long-term care for your client, you must think about their health. It is their health, not their pocketbook that determines if long-term care insurance makes sense.

Date of Birth: _____ Height: _____ Weight: _____

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

Have you previously been declined for long-term care insurance? Yes No
Are you receiving Social Security Disability Income? Yes No

List all prescription medications taken over the past 12 months:

1. Medication: _____ Amount: _____ Currently
Taking? Yes No How Long Taking? _____ Reason Prescribed?: _____

2. Medication: _____ Amount: _____ Currently
Taking? Yes No How Long Taking? _____ Reason Prescribed?: _____

3. Medication: _____ Amount: _____ Currently
Taking? Yes No How Long Taking? _____ Reason Prescribed?: _____

4. Medication: _____ Amount: _____ Currently
Taking? Yes No How Long Taking? _____ Reason Prescribed?: _____

5. Medication: _____ Amount: _____ Currently
Taking? Yes No How Long Taking? _____ Reason Prescribed?: _____

- 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 or Cooking? (Circle all that apply) 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? (Circle all that apply) Yes No



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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

Alzheimer's Disease

Mental Retardation

Multiple Myeloma

Multiple Strokes or TIA's

Osteoporosis with fractures

Parkinson's Disease

Dementia/Confusion/Memory Loss

Cerebral Atrophy

Liver Cirrhosis

ALS (Lou Gehrig's Disease)

Crest

Metastatic Cancer

Cystic Fibrosis

Muscular Dystrophy

Scleroderma

Post Polio Paralytic Syndrome

Spinal Cord Injury

Kidney Failure

Schizophrenia

Within the last 10 years, have you received medical advice, diagnosis or treatment for any of the following? (Circle all that apply) Yes No

Amputation

Autoimmune Disorder

Dizziness

Arthritis (Gold Steroid/Chronic Steroid)

Blindness/Macular Degeneration

Falls

High Blood Pressure

Bronchitis/Asthma

Fibromyalgia

Mental/Nervous Disorder

COPD/Emphysema

Urinary Incontinence

Stroke/TIA

Diabetes Mellitus (What type ____ & Insulin units per day ____)

Elevated PSA or Prostate Disorders (PSA levels ____)

Osteoporosis (Bone Density test t-scores)

Anemia

Angioplasty/Bypass Surgery

Back Disorder/Surgery

Epilepsy/Seizures

Drug or Alcohol Abuse

Blood Disorder

Heart Problems

Joint Replacement/Fractures

Cancer

Neurological Disorder

Peripheral Vascular Disease

Ulcerative Colitis/Crohn's Disease

Hepatitis

If you answered "Yes" to any of the previous questions, provide full details here:

Diagnosis: _____ Date: _____

Treatments: _____ Prognosis: _____

Medications: _____

Diagnosis: _____ Date: _____

Treatments: _____ Prognosis: _____

Medications: _____

Give details on any surgery or procedure (i.e., angioplasty, bypass surgery, pacemaker, defibrillator)

Procedure: _____ Date: _____

Treatment or Therapy _____

Residual Problems: _____

**List additional medications, diagnosis or procedures
on a separate page and attach to this document**