Long Term Care Insurance Medical Pre-Screening Questionnaire

Resident State:			
Client Name:	Age/DOB	Smoker?	Height & Weight:
Spouse Name:	Age/DOB	Smoker?	Height & Weight:

PERSONAL HEALTH HISTORY

Mark "C" for Client, "S" for Spouse or "B" for both if diagnosed /treated in the last 10 years with any of the following conditions.

	Condition		Condition		Condition		Condition		Condition		Condition
	Abnormal blood pressure		Anemia		Cancer –List Type		Coronary Artery Disease		Heart Attack		**Parkinson's Disease***
	Alcohol or Drug Abuse		Arthritis – List Type		Cerebral Vascular Disease		**Dementia or Memory Loss***		**Multiple Sclerosis***		Seizures
	ALS*		Asthma		Congestive Heart Failure		Diabetes Insulin Dependent		**Neuropathy***		Stroke
	Alzheimer's		Atrial Fibrillati		COPD		Emphysema		Osteoporosis		TIA

MEDICATIONS

Client-Additional			**Spouse-Additional**		
Medication(s)	Reason for Medication	Dosage	Medication(s)	Reason for	Dosage

Answer "Yes" or "No" to the following questions

	Client	Spouse
Are you currently using oxygen, a wheelchair, crutches, or cane?		
Are currently in a nursing home or receiving home health care?		
Are you eligible for Medicaid or Medi-Cal in CA. (Welfare)?		
Are you currently receiving disability benefit?		
Are you receiving any physical therapy?		
Have you used tobacco in the last 24 months?		
Do you have any pending or recommend surgeries scheduled?		
Do you have any physical limitations?		

ADDITIONAL HEALTH INFORMATION

Please list any additional information regarding conditions listed above and also any other medical

Client	**Spouse**