Long Term Care Health Pre-Screen Report

For EACH Person-Please fill out a separate form, check YES or NO beside each question.
Answering yes to any question does not mean that you are not eligible for coverage.

Name_____________________________ **Date of Birth** _________________ **ZIP Code**___________

Height ____________ pounds **Weight** ________feet ________inches

1. Do you currently have, or have you ever had a diagnosis for:
Alzheimer's Disease, Huntington's Chorea, Multiple Sclerosis, Schizophrenia, Amyotrophic Lateral Sclerosis, Memory Loss, Muscular Dystrophy, Scleroderma, Cystic Fibrosis, Mental Retardation, Myasthenia Gravis, Spinal Cord Injury, Dementia, Multiple Myeloma, Parkinson's Disease, Stroke/CVA.. Yes ☐ No ☐

2. Do you require human assistance or supervision in any of the following activities: eating, dressing, toileting, transferring from bed to chair, walking, maintaining continence, and bathing?....................................... Yes ☐ No ☐

3. Do you currently reside in, have you been advised to enter, or are you planning to enter:
a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care? .... Yes ☐ No ☐

4. Do you currently use one of the following medical devices: wheelchair, walker, hospital bed, quad cane, oxygen, stair lift, and dialysis?.. Yes ☐ No ☐

5. Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?.. Yes ☐ No ☐

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6. Have you consulted with your primary care physician within the past 18 months................ Yes ☐ No ☐

7. Have you used tobacco products
(cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months? ……………………………. Yes ☐ No ☐

8. WITHIN THE LAST 10 YEARS, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions?

A. **Circulatory Disorders:** Transient Ischemic Attack, Amaurosis Fugax, Heart Arrhythmias, Valvular Disease, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Coronary Artery Disease, High Blood Pressure, Peripheral Vascular Disease, Carotid Artery Disease, Embolisms.. Yes ☐ No ☐

B. **Endocrine and Pituitary Disorders:**
Diabetes, Addison's Disease, Pancreatitis, Cushing's Disease …………………………………..... Yes ☐ No ☐

C. **Cancers:**
Leukemia, Lymphoma, Tumors, Melanoma, Squamous Cell, Sarcomas................................... Yes ☐ No ☐

D. **Genitourinary Disorders:**
Renal Insufficiency, Kidney Failure, Incontinence, Prostate Disorders, Bladder Disorders …….. Yes ☐ No ☐

E. **Gastrointestinal Disorders:**
Hepatitis, Ulcerative Colitis, Crohn's Disease, Liver Disorders, Cirrhosis.................................... Yes ☐ No ☐

F. **Neurological Disorders:** Cerebral Atrophy**,** Mental Illness, Depression, Seizures, Tremors, Neuropathy, Syncope, Anxiety, Chronic Fatigue Syndrome……………………………………………………………………. Yes ☐ No ☐

G. **Blood Disorders:** Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis Yes ☐ No ☐

I. **Musculoskeletal Disorders:** Osteoporosis, Arthritis, Rheumatoid Arthritis, Osteoarthritis, Fractures, Fibromyalgia, Degenerative Joint Disease, Scoliosis, Spinal Stenosis, Lupus, Polymyalgia Rheumatica, Osteopenia, Paralysis, Crest... Yes ☐ No ☐

J. **Respiratory Disorders:** Emphysema, Bronchitis, Asthma, Bronchiectasis, Asbestosis, Sarcoidosis, Chronic Obstructive Pulmonary Disease .... Yes ☐ No ☐

K. **Eye & Ear Disorders:** Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Labrynthitis, Meniere's/Vertigo.. Yes ☐ No ☐

L. **Substance Abuse:** ,Alcoholism, Drug dependency, Illicit drug use .... Yes ☐ No ☐

M. Within the last 10 years have you been hospitalized or have you consulted or been treated by a member of the medical profession for any reason not previously stated?.. Yes ☐ No ☐

N. Within the last 5 years has any surgery or test(s)
been recommended that have not been performed?... Yes ☐ No ☐

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O. Have you ever had an application for life, accident, medical or health, disability or long-term care insurance declined, postponed, modified or rated?.. Yes ☐ No ☐

If YES, list medical reason: ____

P. Are you receiving any disability benefits?.. Yes ☐ No ☐

If YES, What kind (from who) list medical reason: ____

Disability %

9. MEDICAL HISTORY DETAILS –

If you answered YES to any of questions in section 8, provide full detail here.

Quest#	*Diagnosis, Disorder and/or Reason*	*Diagnosis Date*	*Treatment Date*	*Explanation or Comments*

10. MEDICATIONS –

List all prescription medications taken at any time over the past 12 months

If you are taking multiple medications or there has been a change in your health records please send lab reports and summaries for the last three years and/or a physician's statement regarding status.

Medication	*Dosage*	*Frequency*	*Reason Prescribed*

I understand that this information will be kept in the strictest confidence and used only to get an estimate from an insurance company. This is not an offer of insurance and no insurance should be considered bound unless you receive notice in writing from an insurer. This information is true and accurate.

______________________________ ______________________________ ____________

Name Signature Date