Long-Term Care Insurance Pre-Screen

Resident State:_____

Thank you for completing this brief questionnaire. Doing so will help us determine which company will be most receptive to your health profile.
Please use an additional sheet of paper if necessary.

Applicant Name:_____ **Gender:** Male Female **Date of Birth:**_____ **Height:**_____ **Weight:**_____
(as recorded on last doctor's visit)

1. **In the past 5 years, have you used any tobacco products?** Yes No If yes, what type/how often:_____

2. **Do you currently require assistance with any of the following activities?** Bathing Continence Dressing Eating Toileting Walking

3. **Have you ever been confined to a nursing or rehabilitation facility or needed assistance with any of the activities listed in #2?** Yes No
   If yes, please explain when and for what reason: _____

4. **Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following:** (Circle if yes)

Arthritis (Osteo/Rheumatoid)	Depression/Anxiety	Diabetes (Type I/Type II)	AIDS/HIC	Multiple Sclerosis
Joint Replacements	High Blood Pressure	Dizziness/Falls	Alzheimer's Disease/Dementia	Muscular Dystrophy
Osteoporosis/Fractures	Heart Disease	Liver Disease	Asthma/COPD	Parkinson's Disease
Cancer	Kidney Disease	Sleep Disorders	Memory Loss	Stroke or TIA

   If you answered yes, please include for each condition, date of diagnosis, treatment received, and if you are still under treatment.

   _____

   _____

   _____

   _____

5. **Please complete the following chart to reflect any prescription medications you have taken in the past 12 months:**

Medication Name	Prescribed For	Current Dosage/ Taken How Often	Indicate changes made to dosage in past 12 months. *If no longer taking, please indicate month last used.*	Have you stopped taking it, even though it is prescribed? If so, why?

6. **Have you been hospitalized, consulted with or been treated by a medical professional for any reasons not listed above?** Yes No
   If yes, please explain. Please include date diagnosed, treatment received, and if you are still under treatment.

   _____

   _____

7. **Are you currently under any post-operative care, like physical therapy?** If yes, please explain: _____

8. **Have any surgeries or tests been recommended that have yet to be completed?** If yes, please explain:_____