Preliminary Medical and Health Review

Prior to our meeting, please take a minute to complete this **confidential** questionnaire. It helps me advise you on insurability and rates, and perhaps even find a discount. It also helps me recommend the best company for your health conditions. Please complete all pages and return to me ASAP prior to our meeting. *Thank you!*

Email: _____ **OR** **FAX to:** _____

Applicant A	**Applicant B**
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other - Title _____ ☐ Married ☐ Single ☐ Widowed	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other - Title _____ ☐ Married ☐ Single ☐ Widowed
Name: _____	Name: _____
Name or nickname you go by: _____	Name or nickname you go by: _____
Occupation: _____	Occupation: _____
Birthdate: _____ Age: _____	Birthdate: _____ Age: _____
Birthplace: _____ Height: _____ Weight _____	Birthplace: _____ Height: _____ Weight _____
Daytime Phone: (____) _____	Daytime Phone: (____) _____
Evening Phone: (____) _____	Evening Phone: (____) _____
Email Address: _____	Email Address _____
Street address: _____	Mailing Address: _____

If filling this out online, the "underline" feature does not work. Indicate applicable conditions in email/fax.

Applicant A Yes/No **Please check the "Yes" or "NO" box on every question. If Yes, please underline all applicable conditions.** **Applicant B Yes/No**

Y N **1. Do you currently have, or have you *ever* had a diagnosis or treatment for:** Y N
Alzheimer's, Amyotrophic Lateral Sclerosis (ALS), Cerebral Atrophy, Cirrhosis, Cystic Fibrosis, Crest. Dementia, Diabetes *with insulin* (regardless of units), Kidney Failure, Memory Loss, Mental Retardation, Metastatic Cancer, Mixed Connective Tissue Disease, MS, Muscular Dystrophy, Neurological conditions affecting the brain or spinal cord, Multiple Myeloma, Organic Brain Syndrome, Parkinson's, Post-Polio Paralytic Syndrome, Schizophrenia, Scleroderma, Spinal Cord Injury, Myasthenia Gravis, Stroke/CVS, more than one Transient Ischemic Attack (TIA)

Y N **2. Do you require human assistance or supervision in any of the following activities:** Y N
Eating, dressing, toileting, transferring from bed to chair, maintaining continence, bathing, walking, house cleaning, meal preparation, shopping, laundry, transportation, taking medications?

Y N **3. Do you currently reside in, have you been advised to enter, or are you planning to enter:** Y N
A nursing home, Assisted Living Facility or other custodial facility, or are you currently receiving any form of care services or supervision?

Y N **4. In the past 6 months, have you used any of the following? Underline all applicable:** Y N
Wheelchair, walker, hospital bed, quad cane, oxygen equipment, stair lift, motorized scooter, chair lift, dialysis or do you have a handicap plaque or license plate for your own use?

5. Who is your primary care doctor:

Applicant A (doctor with most of your medical records)	**Applicant B (doctor with most of your medical records)**
Doctor's Name: _____	Doctor's Name: _____
Address: _____	Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Phone: (___) _____	Phone: (___) _____
Date Last Seen (month/year): _____	Date Last Seen (month/year): _____
Reason Last Seen: _____	Reason Last Seen: _____
Approximate Date of Last Physical Exam: _____	Approximate Date of Last Physical Exam: _____

Please list *ALL* medications taken or prescribed in the last 24 months, including dosage and reason for each.

Applicant A			**Applicant B**		
Medication	**Dosage**	**Reason Taken**	**Medication**	**Dosage**	**Reason Taken**

If filling this out online, the "underline" feature does not work. Indicate applicable conditions in email/fax.

Applicant A Yes	Applicant A No		Applicant B Yes	Applicant B No
		6. In the last 5 years, (10 years for cancer), have you *ever* received medical advice, diagnosis or treatment or consulted with the medical profession for any of the following conditions? Please indicate yes/no and underline all that apply:		
◯	◯	• **Circulatory Disorders: High Blood Pressure**, Amaurosis Fugax, Aneurysm, Cardiomyopathy, Carotid Artery Disease, Congestive Heart Failure, Coronary Artery Disease, Embolism, Heart Arrhythmias, Peripheral Vascular Disease, Transient Ischemic Attack (TIA), Vascular Disease.	◯	◯
◯	◯	• **Endocrine & Pituitary Disorders: Diabetes**, Addison's, Cushing's, Pancreatitis.	◯	◯
◯	◯	• **Cancers:** Leukemia, Melanoma, Sarcomas, Squamous Cell, or Tumors.	◯	◯
◯	◯	• **Genitourinary:** Bladder, Incontinence, Prostate, or Renal Insufficiency Disorder.	◯	◯
◯	◯	• **Gastrointestinal:** Crohn's, Hepatitis, Cirrhosis of the Liver, or Ulcerative Colitis	◯	◯
◯	◯	• **Neurological: Anxiety**, Bipolar Syndrome, Chronic Fatigue Syndrome, **Depression**, Mental Illness, Neuropathy, Seizures, Syncope (fainting).	◯	◯
◯	◯	• **Blood:** Anemia, Hemochromatosis, Polycythemia Vera, Thrombocytopenia,	◯	◯
◯	◯	• **Musculoskeletal: Arthritis**, Rheumatoid Arthritis, Osteoarthritis, Degenerative Joint Disease, Fibromyalgia, Fractures, Lupus, Polymyalgia Rheumatica, Scoliosis, Spinal Stenosis, Osteopenia, **Osteoporosis**	◯	◯
◯	◯	• **Respiratory: Asthma**, Allergy-induced asthma or seasonal asthma, Bronchitis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Asbestosis, Sarcoidosis.	◯	◯
◯	◯	• **Eye & Ear:** Glaucoma, Macular Degeneration, Meniere's/Vertigo, Retinitis Pigmentosa.	◯	◯
◯	◯	• **Substance Abuse: Alcoholism**, Drug Dependency, Illicit Drug Use	◯	◯
◯	◯	**7. TOBACCO:** Have you used any form of tobacco in the past 3 years? If you ever used tobacco, when did you quit? Applicant A _____ Applicant B _____	◯	◯
◯	◯	**8. Within the last 10 years (excluding childbirth without complications) have you ever been:** hospitalized, treated by or consulted with a member of the medical profession for ANY reason not already indicated above? If yes, please give details:_____	◯	◯
◯	◯	**9. In the last 12 months, have you had *ANY* therapy, injections, narcotic pain killers (Vicodin, Percocet, etc.) or any cortisone shots? If so, details:** _____	◯	◯
◯	◯	**10. In the last 5 years, have any surgeries, injections or tests been recommended that have *NOT* yet been performed? If yes, details:** _____	◯	◯
◯	◯	**11. Have you ever had an application for life, accident, medical or health, disability or long term care insurance declined, postponed, modified or rated? If yes, why, when and which company? Details:**_____	◯	◯
◯	◯	**12. Are you receiving any disability benefits such as Social Security disability, V.A. disability or Worker's Comp? Underline any applicable.**_____	◯	◯
◯	◯	**13. Do you currently have any long term care policy already in force? If yes, which company?** _____	◯	◯
◯	◯	**14. Are you currently eligible for, and covered by Medicaid?**_____	◯	◯
◯	◯	**15. Have any of your immediate family members (father, mother, brother, sister) had a history of:** Diabetes, Heart Disease, Stroke, Parkinson's, Alzheimer's or Dementia or Huntington's? **If yes, details: Applicant A** _____ **Applicant B** _____	◯	◯
◯	◯	**16. Have you ever expressed concerns about your memory to your doctor?**	◯	◯

If you need additional space to list more medications, or for any other reason, please use additional page(s) and include it in your reply. Thank you!

Scan and Email to: _____ **OR Fax:**_____