Long Term Care Medical Pre-Screening Questionnaire

Fax to 714-377-9562

Email to: Karol@kchealthinsurance.com

Health Information For: _____ **DOB** _____ **Date:** _____

Marital Status? _____ **Is Your Spouse Applying?** _____ 1/12/2016

Current Height_____ **Weight**_____ *(by scale)* **Gender: Male / Female** *(please circle)*

Do You Use Tobacco? Yes or No (Have you stopped in the last 5 years?) Y /N When ____

Date of last Complete Physical with Labs/Bloodwork? _____ **Blood Pressure Readings?** _____

Have you had or do you currently have any of the following conditions? If so, you may not apply for LTC.

ALS (Lou Gehrig's disease)	Cystic Fibrosis	HIV	Muscular Dystrophy
Alzheimers Disease	Dementia	Huntington's Chorea	Parkinson's Disease
Cirrhosis of the Liver	Diabetic Neuropathy	Multiple Sclerosis (MS)	

Family History?

Do you have a Parent diagnosed with Coronary Artery Disease prior to age 60? Yes or No
Do you have one Parent diagnosed with Dementia prior to age 70? Yes or No
Do you have both Parents diagnosed with Dementia prior to age 70? Yes or No

	Yes	No
In the past ten years, have you been hospitalized? If Yes, Date _____ Reason _____		
Do you use any of the following: CANE (single-prong or quad-cane), WALKER or WHEELCHAIR? OXYGEN? (Use of a quad-cane, walker or wheelchair, or oxygen will generally disqualify an applicant). Do you have a Handicap Parking Permit? Y / N Why? _____		

Do you take prescription medications? If Yes, Complete details below:

Prescription Name	Condition	Dosage	Frequency	Date Started	Prescription Changes in the past 6 months

	Yes	No
Are You Currently Receiving Disability Benefits? If yes, what type of disability are you receiving? Circle: **Military, Social Security** or **Private?** Please provide reason for disability? _____ and %___		

Have you ever been treated for any of the following conditions?

Please provide as much info as possible…

	Yes	No
CANCER? **Date Diagnosed?** _____Type_____Stage____ Metastatic (spreading)? Y / N Any lymph node involvement? Y / N How many nodes checked? ____ Number Positive_____ **Treatment:** Surgery _____ Chemotherapy _____ Radiation _____ Date treatment completed? _____		
DIABETES? Date Diagnosed?_____Type _____ Treated with Diet / Oral Meds / Insulin ? A1C# _____ FBS# _____ *(Please provide actual # -A1C# usually between 5-9 and FBS# usually between 130-190).* **If insulin dependent**: indicate how many units per day? _____ Most Units taken in any one day over the past year? _____ **Any diabetic complications** such as retinopathy, neuropathy (numbness or tingling), kidney problems, skin ulcers? Y / N *(Please circle any that apply).* **When was your last medication or treatment change?** _____		

STROKE? Date Diagnosed_____; **TIA?** Date Diagnosed? _____(referred to as "mini-stroke") Any functional limitations or residuals? _____ If more than 1 event, indicate number of events and dates_____	**Yes**	**No**
HEART CONDITIONS? If Yes…Please answer the following questions… Date Diagnosed? _____ Type of Heart Condition _____ Treatment _____ Degree of Recovery? _____	**Yes**	**No**
CONGESTIVE HEART FAILURE (CHF)? If yes, when? _____ Has there been more than one episode? _Y/N_ If yes, how many? _____	**Yes**	**No**
ARTHRITIS? (Osteo or Rheumatoid) What joints are affected? _____ Any joint replacements? **Y / N** How Many? _____When?_____ Steriod Use? **Y / N** **Have you ever received injections?** **Y / N** When was your last injection? _____ Are you scheduled for more injections? **Y / N**	**Yes**	**No**
Are you **PENDING SURGERY** or been advised to have **Surgery or Medical Testing** that has not yet been completed? If Yes, when is it scheduled? _____ What surgery or procedure has been recommended? _____	**Yes**	**No**
Are You Currently Receiving Physical Therapy? Y / N **If yes**, For What _____ **Have You Recently Completed Physical Therapy?** Y / N **If yes,** Date Completed? _____ For What? _____		
Do you have Memory Concerns or Have You Discussed Memory issues with your Physician?		
OTHER CONDITIONS: Please list any diagnosed medical conditions not listed above.		

FOR WOMEN ONLY:

HAVE YOU HAD A BONE DENSITY TEST DONE? **If YES… Is There Bone Loss?** **Y /N** If Yes, Do you know what your "T" and "Z" scores are? (These scores can be obtained from the doctors' office that administered the test; usually, no more than 2-3 pages long). **HAVE YOU HAD ANY FRACTURES?** **Y / N** If yes, **What** _____ & **When?** _____	**Yes**	**No**

FOR MEN ONLY:

HAVE YOU HAD A PROSTATE EXAM? **IF YES….** WHAT ARE YOUR P.S.A. LEVELS? _____ **PROVIDE DETAILS….If positive for prostate cancer or elevated PSA, indicate type of treatment plan or surgery and a follow-up PSA score.**	**Yes**	**No**

If you have additional medical information to share, please feel free to provide those details on a separate sheet of paper. This information helps us to determine if you are eligible to apply for Long Term Care. It is not an indication you will be accepted by the carrier with which you apply. Approval will be determined by the carrier's underwriting department once all the underwriting requirements are met. Please call AoCP with any questions…