LONG TERM CARE INSURANCE
PRELIMINARY HEALTH QUESTIONNAIRE

Applicant's Name: Date of Birth:

1. Height: Weight:

2. Have you used tobacco products in the last 12 months? ❑ Yes ❑ No

3. Within the last 5 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 (includes Hypertension)	❑ Yes	❑ No
B. Endocrine and pituitary disorders (includes Diabetes)	❑ Yes	❑ No
C. Cancers	❑ Yes	❑ No
D. Genital urinary disorders	❑ Yes	❑ No
E. Gastrointestinal disorders	❑ Yes	❑ No
F. Neurological disorders	❑ Yes	❑ No
G. Blood disorders	❑ Yes	❑ No
H. Musculoskeletal disorders	❑ Yes	❑ No
I. Respiratory disorders	❑ Yes	❑ No
J. Eye and ear disorders	❑ Yes	❑ No
K. Substance or Alcohol Abuse	❑ Yes	❑ No

4. Have you had any surgery recommended or anticipated? ❑ Yes ❑ No

5. Are you currently receiving any physical therapy? ❑ Yes ❑ No

6. Do you currently use any assistive or mechanical devices? ❑ Yes ❑ No

7. Have you ever received home health care or been confined to a nursing home or rehabilitation facility? ❑ Yes ❑ No

8. Do you require human assistance or supervision in performing any of your activities of daily living? ❑ Yes ❑ No

9. Have you had a complete physical exam within the past 18 months? ❑ Yes ❑ No

Details to Questions 3 – 9:

Q #	Diagnosis	Diagnosis Date	Treatment
Q #	Diagnosis	Diagnosis Date	Treatment
Q #	Diagnosis	Diagnosis Date	Treatment
Q #	Diagnosis	Diagnosis Date	Treatment

List all prescription medications:

The information on this form is strictly confidential and is for internal use only.