

## HEALTH HISTORY QUESTIONNAIRE

The first step in long-term care expense planning is determining insurability. Long-term care insurance is medically underwritten. Health history will determine carrier, product and ultimately the cost of a policy. Please complete the information below, providing as much detail as possible, to begin the planning process.

### 1. PERSONAL INFORMATION

Marital Status:    Married    Single    Divorced    Widowed

	Client	Spouse/Partner
Name		
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		
City / State / ZIP		
Home Phone		
Work Phone		
Fax Number		
E-mail		
	DOB:                      Age:	DOB:                      Age:
	Height:                      Weight:	Height:                      Weight:
Do you work full-time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please fax completed form to Gurley LTCI at 480.515.2713 or scan/e-mail to [nicole@gurleyltci.com](mailto:nicole@gurleyltci.com)

## 2. CAN YOU QUALIFY?

### *CLIENT*

### *SPOUSE/PARTNER*

Yes  No

Yes  No

Do you use mechanical devices such as a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stair lift? Please circle all that apply.

Yes  No

Yes  No

Are you cognitively impaired or do you currently need or receive help in doing any of the following activities of daily living (ADLs): bathing, eating, dressing, toileting, transferring or maintaining continence? Please circle all that apply.

Yes  No

Yes  No

Have you had another long term care insurance policy in force during the last 12 months? If so, with which company: \_\_\_\_\_

Yes  No

Yes  No

Are you currently covered by Medicaid (not Medicare)?

Yes  No

Yes  No

Are you currently receiving Disability, Worker's Compensation, or Social Security Disability Benefits? Please circle all that apply.

Yes  No

Yes  No

Do you intend to replace any of your medical or health coverage with the coverage applied for? (This is not medical or health insurance coverage.)

Yes  No

Yes  No

Have you had a gain or loss of more than 10 pounds in the last 12 months? If yes, please explain: \_\_\_\_\_

Yes  No

Yes  No

Have you used tobacco products (smoked, chewed, or used nicotine delivery system) including pipes and cigars in the last five years? Please circle all that apply.

Yes  No

Yes  No

Have you been advised to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs?

Yes  No

Yes  No

Have you been hospitalized in the past five years? Please explain: \_\_\_\_\_

Yes  No

Yes  No

Has surgery or any diagnostic testing been recommended but not performed? Please explain:  
\_\_\_\_\_

Yes  No

Yes  No

Have you ever been declined for long-term care insurance or life insurance? If so with which carrier and why?  
\_\_\_\_\_

**Have you ever been diagnosed with any of the following conditions?  
Please circle all that apply and provide details on Page 4.**

Condition #	Condition	Client	Spouse/Partner
1	AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Alcohol or Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	ALS (Lou Gehrig's disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Alzheimer's Disease, Dementia, Senility or Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Angioplasty or Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Arrhythmia or Atrial Fibrillation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Asthma or Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Cancer (Please see page 6 or 7)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Carotid or other Arterial Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Cirrhosis of the Liver	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	CREST Syndrome or Scleroderma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Depression, Anxiety or Bipolar	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14	Diabetes (Please see Page 6 or 7)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15	Disabling Back or Spine Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
16	Discoïd or Systemic Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
17	Emphysema/COPD or lung disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
18	Epilepsy, Seizures or Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
19	Fainting Spells or Blacking Out	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
20	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
21	Glaucoma, macular degeneration or other eye disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
22	Heart Attack or Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
23	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
24	Hodgkin's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
25	Huntington's Chorea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
26	Hypertension or High Blood Pressure (Please see Page 6 or 7)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
27	Immune System Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
28	Irritable Bowel Syndrome or Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
29	Joint Replacement Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
30	Kidney Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
31	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
32	Multiple Myeloma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
33	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
34	Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
35	Myasthenia Gravis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
36	Organic Brain Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
37	Osteoporosis or Osteopenia (Please see page 6 or 7)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
38	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
39	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
40	Post-Polio Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
41	Rheumatoid Arthritis or Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
42	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
43	Stroke or Multiple Transient Ischemic Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you checked "Yes" to any of the conditions listed on Page 3, please provide details below:

***CLIENT:***

Condition #	Date First Diagnosed	Current Status	Date of Last Treatment

***SPOUSE/PARTNER:***

Condition #	Date First Diagnosed	Current Status	Date of Last Treatment

What medications are you taking?

***CLIENT:***

Drug	Date First Prescribed	Reason Taken	Dosage

***SPOUSE/PARTNER:***

Drug	Date First Prescribed	Reason Taken	Dosage

**Medical conditions you are treated for but previously not detailed in this questionnaire.**

<b>Client or Spouse:</b>	<b>Year Diagnosed</b>	<b>Medical Condition</b>	<b>Name of Doctor/Specialty</b>

**Surgeries or hospital stays in the last 10 Years: If NONE, check this box**

<b>Client or Spouse:</b>	<b>Year</b>	<b>Procedure</b>	<b>Name of Doctor/Facility</b>

**When was your last physical exam?**

***CLIENT:***

<b>Primary Physician:</b>	
<b>Date of Last Physical:</b>	<b>Outcome of Physical: New diagnoses or medications?</b>
<b>Date of Last Blood Work:</b>	
<b>Date of Last Visit</b>	<b>Reason for Visit:</b>

**When was your last physical exam?**

***SPOUSE/PARTNER:***

<b>Primary Physician:</b>	
<b>Date of Last Physical:</b>	<b>Outcome of Physical: New diagnoses or medications?</b>
<b>Date of Last Blood Work:</b>	
<b>Date of Last Visit</b>	<b>Reason for Visit:</b>

**Additional health information related to blood pressure, cholesterol and osteoporosis.**

**CLIENT:**

What is your latest blood pressure reading? Less than 145/85? 146/86 to 159/99? 160/100 or greater?

What is your total cholesterol? \_\_\_\_\_ What is your cholesterol ratio? \_\_\_\_\_

What are your T-scores? -1.1 to -2.5? -2.6 to -3.5? -3.6 or greater? When last reading taken? \_\_\_\_\_

**Additional health information related to cancer.**

When was the cancer diagnosed?

What type of cancer and where was it located?

At the time of diagnosis, what was the stage: (1, 2, 3, or 4) and grade: (A, B, C or D)?

Were any lymph nodes positive? If so, how many?

What was the treatment protocol? Surgery? Chemotherapy? Radiation? Combination?

When were you released from treatment? (Month/Year)

If prostate cancer, when were the last PSA and Gleason Score done? What were the readings?

**Additional health information related to diabetes.**

What type of diabetes do you have? Juvenile onset Type I? Adult onset Type II?

When was it diagnosed (Month/Year)?

What is the treatment? Diet only? Oral medicine? Insulin injections? Insulin pump? Number of CCs or units?

When was the last blood sugar test done? What was the reading?

When was the last A1c done? What was the reading?

Have there been any complications? Foot ulcers? Vision problems? Kidney damage? Neuropathy?

**Additional health information about your parents.**

Was either of your parents diagnosed with coronary artery disease prior to age 60?  Yes  No

Was either of your parents diagnosed with dementia prior to age 70?  Yes  No

Were both of your parents diagnosed with dementia prior to age 70?  Yes  No

**Additional health information related to blood pressure, cholesterol and osteoporosis.**

***SPOUSE/PARTNER:***

What is your latest blood pressure reading? Less than 145/85? 146/86 to 159/99? 160/100 or greater?
What is your total cholesterol? _____ What is your cholesterol ratio? _____
What are your T-scores? -1.1 to -2.5? -2.6 to -3.5? -3.6 or greater? When last reading taken? _____

**Additional health information related to cancer.**

When was the cancer diagnosed?
What type of cancer and where was it located?
At the time of diagnosis, what was the stage: (1, 2, 3, or 4) and grade: (A, B, C or D)?
Were any lymph nodes positive? If so, how many?
What was the treatment protocol? Surgery? Chemotherapy? Radiation? Combination?
When were you released from treatment? (Month/Year)
If prostate cancer, when were the last PSA and Gleason Score done? What were the readings?

**Additional health information related to diabetes.**

What type of diabetes do you have? Juvenile onset Type I? Adult onset Type II?
When was it diagnosed (Month/Year)?
What is the treatment? Diet only? Oral medicine? Insulin injections? Insulin pump? Number of CCs or units?
When was the last blood sugar test done? What was the reading?
When was the last A1c done? What was the reading?
Have there been any complications? Foot ulcers? Vision problems? Kidney damage? Neuropathy?

**Additional health information about your parents.**

Was either of your parents diagnosed with coronary artery disease prior to age 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was either of your parents diagnosed with dementia prior to age 70?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were both of your parents diagnosed with dementia prior to age 70?	<input type="checkbox"/> Yes <input type="checkbox"/> No