

# LONG TERM CARE INSURANCE HEALTH AND PREFERENCE QUESTIONNAIRE

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Gender: \_\_\_\_\_  
Residence State: \_\_\_\_\_  
Height: \_\_\_\_\_  
Weight: \_\_\_\_\_  
Tobacco Use: \_\_\_\_\_

1. Current Medications – Need name of medicine, dosage, frequency and medical condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. List any medications which have been prescribed but are NOT being taken. Why not? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Are you currently under a doctor's care for any health condition or have you received long-term care in the past three years? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you have any physical limitations (e.g. history of back or knee problems?) or have you experienced any 'falls' in the past two years? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Do you drive a car and manage/handle your own finances? \_\_\_\_\_ If not, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

6. Have you ever been declined for Long Term Care Coverage? \_\_\_\_\_ If so, please explain why:  
\_\_\_\_\_  
\_\_\_\_\_

7. Please describe significant health history, including surgeries considered or performed, arthritis, osteoporosis, health issues, cancer, kidney issues, diabetes, memory loss, depression, strokes, TIAs, etc. What happened? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When? \_\_\_\_\_ Level of the disease? \_\_\_\_\_

What treatment did you received? \_\_\_\_\_

When did treatment stop? \_\_\_\_\_

Residual issues or treatment? \_\_\_\_\_

Related Conditions? \_\_\_\_\_