GURLEYLTCI
Long-Term Care Expense Planning

HEALTH HISTORY QUESTIONNAIRE

DATE _____

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	❑Male ❑Female	❑Male ❑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?	❑ Yes ❑ No	❑ Yes ❑ No

Please fax completed form to Gurley LTCI at 480.515.2713 or scan/e-mail to 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, CPAP 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 12 months? 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	❑Yes ❑No	❑Yes ❑No
2	Alcohol or Drug Addiction	❑Yes ❑No	❑Yes ❑No
3	ALS (Lou Gehrig's disease)	❑Yes ❑No	❑Yes ❑No
4	Alzheimer's Disease, Dementia, Senility or Memory Loss	❑Yes ❑No	❑Yes ❑No
5	Angioplasty or Heart Surgery	❑Yes ❑No	❑Yes ❑No
6	Arrhythmia or Atrial Fibrillation	❑Yes ❑No	❑Yes ❑No
7	Asthma or Chronic Bronchitis	❑Yes ❑No	❑Yes ❑No
8	Back of Spine Condition	❑Yes ❑No	❑Yes ❑No
9	Cancer (Please see page 6 or 7)	❑Yes ❑No	❑Yes ❑No
10	Carotid or other Arterial Surgery	❑Yes ❑No	❑Yes ❑No
11	Cirrhosis of the Liver	❑Yes ❑No	❑Yes ❑No
12	CREST Syndrome or Scleroderma	❑Yes ❑No	❑Yes ❑No
13	Cystic Fibrosis	❑Yes ❑No	❑Yes ❑No
14	Depression, Anxiety or Bipolar	❑Yes ❑No	❑Yes ❑No
15	Diabetes (Please see Page 6 or 7)	❑Yes ❑No	❑Yes ❑No
16	Discoid or Systemic Lupus	❑Yes ❑No	❑Yes ❑No
17	Emphysema/COPD or lung disorder	❑Yes ❑No	❑Yes ❑No
18	Epilepsy, Seizures or Convulsions	❑Yes ❑No	❑Yes ❑No
19	Fainting Spells or Blacking Out	❑Yes ❑No	❑Yes ❑No
20	Fibromyalgia	❑Yes ❑No	❑Yes ❑No
21	Glaucoma, macular degeneration or other eye disease	❑Yes ❑No	❑Yes ❑No
22	Heart Attack or Angina	❑Yes ❑No	❑Yes ❑No
23	Hepatitis A, B or C	❑Yes ❑No	❑Yes ❑No
24	Hodgkin's Disease	❑Yes ❑No	❑Yes ❑No
25	Huntington's Chorea	❑Yes ❑No	❑Yes ❑No
26	Hypertension or High Blood Pressure (Please see Page 6 or 7)	❑Yes ❑No	❑Yes ❑No
27	Immune System Disorder	❑Yes ❑No	❑Yes ❑No
28	Irritable Bowel Syndrome or Crohn's Disease	❑Yes ❑No	❑Yes ❑No
29	Joint Replacement Surgery	❑Yes ❑No	❑Yes ❑No
30	Kidney Failure	❑Yes ❑No	❑Yes ❑No
31	Leukemia	❑Yes ❑No	❑Yes ❑No
32	Multiple Myeloma	❑Yes ❑No	❑Yes ❑No
33	Multiple Sclerosis	❑Yes ❑No	❑Yes ❑No
34	Muscular Dystrophy	❑Yes ❑No	❑Yes ❑No
35	Myasthenia Gravis	❑Yes ❑No	❑Yes ❑No
36	Organic Brain Syndrome	❑Yes ❑No	❑Yes ❑No
37	Osteoporosis or Osteopenia (Please see page 6 or 7)	❑Yes ❑No	❑Yes ❑No
38	Pacemaker or Defibrillator	❑Yes ❑No	❑Yes ❑No
39	Parkinson's Disease	❑Yes ❑No	❑Yes ❑No
40	Post-Polio Syndrome	❑Yes ❑No	❑Yes ❑No
41	Rheumatoid Arthritis or Osteoarthritis	❑Yes ❑No	❑Yes ❑No
42	Sleep Apnea	❑Yes ❑No	❑Yes ❑No
43	Stroke or Multiple Transient Ischemic Attack	❑Yes ❑No	❑Yes ❑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.			
Client or Spouse:	Year Diagnosed	Medical Condition	Name of Doctor/Specialty

Surgeries or hospital stays in the last 10 Years: If NONE, check this box ❑			
Client or Spouse:	Year	Procedure	Name of Doctor/Facility

When was your last physical exam?

CLIENT:

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

When was your last physical exam?

SPOUSE/PARTNER:

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

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 tests 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 tests 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