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 this questionnaire providing as much detail as possible.

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		
E-mail		
	DOB: Age:	DOB: Age:
	Height: Weight:	Height: Weight:
Do you work full-time?	❑ Yes ❑ No	❑ Yes ❑ No

Please scan/e-mail to nicole@gurleyltci.com or fax completed form to 480.515.2713.

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2. CAN YOU QUALIFY? Please circle all issues that apply within each question.

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?
❑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?
❑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 payments including Worker's Compensation or Social Security Disability Insurance, short-term or long-term disability benefits?
❑Yes ❑No	❑Yes ❑No	Do you intend to replace any of your health care insurance with the coverage applied for?
❑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? If yes, please explain: _____
❑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, when and why? _____

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

Number	Conditions	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	Angina, Heart Attack or Congestive Heart Failure	❑Yes ❑No	❑Yes ❑No
6	Angioplasty or Heart Surgery	❑Yes ❑No	❑Yes ❑No
7	Arrhythmia or Atrial Fibrillation	❑Yes ❑No	❑Yes ❑No
8	Arterial or Vascular Disease, Aneurysm, PVD or PAD	❑Yes ❑No	❑Yes ❑No
9	Arthritis, Osteo, Rheumatoid or Psoriatic	❑Yes ❑No	❑Yes ❑No
10	Asthma, Chronic Bronchitis, COPD, Emphysema or Lung Disorder	❑Yes ❑No	❑Yes ❑No
11	Autoimmune Disease, Systemic Lupus, Sjogren's, or Multiple Sclerosis	❑Yes ❑No	❑Yes ❑No
12	Back Condition, Spinal Stenosis, Scoliosis or Spondylosis	❑Yes ❑No	❑Yes ❑No
13	Balance Disorder or Gait Impairment	❑Yes ❑No	❑Yes ❑No
14	Cancer, Leukemia, Lymphoma, Multiple Myeloma or Melanoma (See page 6 or 7)	❑Yes ❑No	❑Yes ❑No
15	Carotid or other Arterial Surgery	❑Yes ❑No	❑Yes ❑No
16	Cerebral Palsy	❑Yes ❑No	❑Yes ❑No
17	Cirrhosis of the Liver	❑Yes ❑No	❑Yes ❑No
18	CREST Syndrome or Scleroderma	❑Yes ❑No	❑Yes ❑No
19	Cystic Fibrosis	❑Yes ❑No	❑Yes ❑No
20	Depression, Anxiety, Bipolar or Schizophrenia	❑Yes ❑No	❑Yes ❑No
21	Diabetes (Please see page 6 or 7)	❑Yes ❑No	❑Yes ❑No
22	Down Syndrome	❑Yes ❑No	❑Yes ❑No
23	Epilepsy, Seizures or Convulsions	❑Yes ❑No	❑Yes ❑No
24	Fainting Spells or Blacking Out	❑Yes ❑No	❑Yes ❑No
25	Fibromyalgia	❑Yes ❑No	❑Yes ❑No
26	Glaucoma, Macular Degeneration or Other Eye Disease	❑Yes ❑No	❑Yes ❑No
27	Hepatitis A, B or C	❑Yes ❑No	❑Yes ❑No
28	Huntington's Chorea	❑Yes ❑No	❑Yes ❑No
29	Hypertension (Please see Page 6 or 7)	❑Yes ❑No	❑Yes ❑No
30	Irritable Bowel Syndrome, Ulcerative Colitis or Crohn's Disease	❑Yes ❑No	❑Yes ❑No
31	Joint Injections or Replacement	❑Yes ❑No	❑Yes ❑No
32	Kidney Failure, Dialysis or Transplant	❑Yes ❑No	❑Yes ❑No
33	Muscular Dystrophy	❑Yes ❑No	❑Yes ❑No
34	Myasthenia Gravis	❑Yes ❑No	❑Yes ❑No
35	Narcotic Pain Killer	❑Yes ❑No	❑Yes ❑No
36	Organ Transplant	❑Yes ❑No	❑Yes ❑No
37	Organic Brain Syndrome	❑Yes ❑No	❑Yes ❑No
38	Osteoporosis or Osteopenia (Please see page 6 or 7)	❑Yes ❑No	❑Yes ❑No
39	Pacemaker or Defibrillator	❑Yes ❑No	❑Yes ❑No
40	Parkinson's Disease	❑Yes ❑No	❑Yes ❑No
41	Post-Polio Syndrome	❑Yes ❑No	❑Yes ❑No
42	Shingles	❑Yes ❑No	❑Yes ❑No
43	Sleep Apnea	❑Yes ❑No	❑Yes ❑No
44	Stroke, Multiple Transient Ischemic Attack or Global Amnesia	❑Yes ❑No	❑Yes ❑No

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If you checked "Yes" to any of the conditions listed on Page 3, please provide details below. If more space is required, please detail on Page 8.

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

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Medical conditions you are treated for and not detailed previously.

Client or Spouse/Partner:	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/Partner	Year	Procedure	Name of Doctor/Facility

When was your last physical exam?

CLIENT:

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

SPOUSE/PARTNER:

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

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

CLIENT:

What was your last blood pressure reading? Less than 145/85? 146/86? 159/99? 160/100? Greater?
What is your total cholesterol? _____ What is your cholesterol ratio? _____
What were your last T-scores (bone density)? -1.1 to -2.5? -2.6 to -3.5? -3.6 or greater? When was the 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? Oral medicine? Insulin injections? Insulin pump? Number of units of insulin daily?
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.

Has either of your parents been diagnosed with coronary artery disease?	❑Yes ❑No
Have both of your parents been diagnosed with coronary artery disease?	❑Yes ❑No
Has either of your parents been diagnosed with dementia?	❑Yes ❑No
Have both of your parents diagnosed with dementia?	❑Yes ❑No

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Have both of your parents diagnosed with dementia?	☐Yes ☐No

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Additional health information.

CLIENT:

SPOUSE/PARTNER:

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