OSBA Insurance Agency
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Phone: 614-572-0627*Fax: 614-572-0617

LTC Pre-Screen Medical Questionnaire

Agent Name _____ Phone Number _____ Email _____

Client #1

Name _____

Date of Birth _____Male/Female_____ State_____

Height Weight

Significant Medical History & Medications

- ☐ Abnormal Blood Pressure
- ☐ AIDS/ARC
- ☐ Alcohol Abuse
- ☐ ALS
- ☐ Alzheimer's Disease
- ☐ Amputation
- ☐ Anemia
- ☐ Aneurysm
- ☐ Arthritis ☐ Osteo ☐ R.A.
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar/Manic Depression
- ☐ Cancer*(see below)
- ☐ Cardiomyopathy
- ☐ Carotid Artery Disease
- ☐ Cerebral Vascular Disease
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Dizziness/Vertigo
- ☐ Drug Abuse
- ☐ Eye Disease
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hodgkin's Disease
- ☐ Joint Replacement
- ☐ Kidney Failure
- ☐ Leukemia
- ☐ Lupus
- ☐ Lymphoma
- ☐ Memory Loss
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Neurogenic Bladder
- ☐ Neuropathy
- ☐ Organ Transplant
- ☐ Organic Brain Syndrome
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular
- ☐ Receiving Physical or Occupational Therapy
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Seizures
- ☐ Stroke or TIA
- ☐ Tremor

Do you have a personal care doctor? ☐ Yes ☐ No

Name Date of Last Visit

☐ Taking Blood Pressure Medication? If known, last reading
☐ Taking Cholesterol Medication? If known, last reading

Family History of diagnosed Alzheimer's Disease or Dementia ☐ Yes ☐ No
Relationship

☐ Receiving Meals on Wheels?
☐ Use a Cane, Walker or Wheelchair?
☐ Tobacco Use? Form?
☐ Marijuana Use? Form?

Requested Benefit Amount

Benefit Period

Have you Previously been Declined for LTC Coverage? ☐ Yes ☐ No

Client #2

Name _____

Date of Birth _____Male/Female_____ State_____

Height Weight

Significant Medical History & Medications

- ☐ Abnormal Blood Pressure
- ☐ AIDS/ARC
- ☐ Alcohol Abuse
- ☐ ALS
- ☐ Alzheimer's Disease
- ☐ Amputation
- ☐ Anemia
- ☐ Aneurysm
- ☐ Arthritis ☐ Osteo ☐ R.A.
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar/Manic Depression
- ☐ Cancer*(see below)
- ☐ Cardiomyopathy
- ☐ Carotid Artery Disease
- ☐ Cerebral Vascular Disease
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Dizziness/Vertigo
- ☐ Drug Abuse
- ☐ Eye Disease
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hodgkin's Disease
- ☐ Joint Replacement
- ☐ Kidney Failure
- ☐ Leukemia
- ☐ Lupus
- ☐ Lymphoma
- ☐ Memory Loss
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Neurogenic Bladder
- ☐ Neuropathy
- ☐ Organ Transplant
- ☐ Organic Brain Syndrome
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular
- ☐ Receiving Physical or Occupational Therapy
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Seizures
- ☐ Stroke or TIA
- ☐ Tremor

Do you have a personal care doctor? ☐ Yes ☐ No

Name Date of Last Visit

☐ Taking Blood Pressure Medication? If known, last reading
☐ Taking Cholesterol Medication? If known, last reading

Family History of diagnosed Alzheimer's Disease or Dementia ☐ Yes ☐ No
Relationship

☐ Receiving Meals on Wheels?
☐ Use a Cane, Walker or Wheelchair?
☐ Tobacco Use? Form?
☐ Marijuana Use? Form?

Requested Benefit Amount

Benefit Period

Have you Previously been Declined for LTC Coverage? ☐ Yes ☐ No