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LTC Pre-Screen Medical Questionnaire

Agent Name	Phone Num		Email_						
Client #1				Client #2					
Name			Name						
Date of BirthMale/Female		State	Date of Bir	ate of BirthMale/Female			State	!	
Height Weight			Height	Weight					
Significant Medic	cal History & Medica	<u>itions</u>	<u>s</u>	ignificant I	Medical His	tory	& Medication	<u>ns</u>	
□ Abnormal Blood Pressure□ AIDS/ARC	☐ Heart Attack ☐ Hepatitis				Blood Pressure	_	Heart Attack		
☐ Alcohol Abuse	☐ Hodgkin's Disease				NICO		Hepatitis Hodgkin's Disease		
□ ALS	☐ Joint Replacement				Juse		Joint Replacemen		
☐ Alzheimer's Disease	☐ Kidney Failure				's Disease		Kidney Failure	-	
☐ Amputation	Leukemia			Amputatio	on		Leukemia		
☐ Anemia	Lupus						Lupus		
☐ Aneurysm	Lymphoma			Aneurysm			Lymphoma		
Arthritis Osteo R.A.	☐ Memory Loss			Arthritis	Osteo R.A.		Memory Loss		
☐ Asthma☐ Atrial Fibrillation	☐ Multiple Sclerosis ☐ Muscular Dystrophy						Multiple Sclerosis		
Atrial FibrillationBipolar/Manic Depression							Muscular Dystrop	=	
☐ Cancer*(see below)	Neurogenic Bladde				anic Depression	_	Myasthenia Grav		
☐ Cardiomyopathy	☐ Neuropathy	1	L				Neurogenic Blado	ler	
☐ Carotid Artery Disease	☐ Organ Transplant						Neuropathy		
☐ Cerebral Vascular Disease		rome			tery Disease		Organ Transplant		
☐ Congestive Heart Failure	☐ Osteoporosis	onic			ascular Disease		Organic Brain Syn	drome	
COPD/Emphysema	☐ Paralysis			_	Heart Failure		Osteoporosis		
Coronary Artery Disease	Parkinson's Disease	<u>.</u>			· ·		Paralysis		
Crohn's Disease	Peripheral Vascular			•	Artery Disease		Parkinson's Disea		
☐ Dementia	•	or Occupational Therapy			sease		Peripheral Vascula Receiving Physica		al Thor
☐ Depression/Anxiety	☐ Rheumatoid Arthri		·		n/Anviety		Rheumatoid Arth		ıı ınera
Diabetes	☐ Scleroderma			Diabetes	i/ Allxiety		Scleroderma	iitis	
Dizziness/Vertigo	Seizures		_	Dizziness/	Vertigo	П	Seizures		
☐ Drug Abuse	☐ Stroke or TIA			_		П	Stroke or TIA		
☐ Eye Disease	☐ Tremor			_			Tremor		
Do you have a personal ca	are doctor? Yes	No	Do	•	personal ca	re do		No	
lame	Date of Last			ime	personal cal	i e ue	Date of Las		
Taking Blood Pressure Med Taking Cholesterol Medicat					essure Medica rol Medication		? If known, last re If known, last re	_	
amily History of diagnosed Alzheimer's Disease or Dementia Yes No elationship				Family History of diagnosed Alzheimer's Disease or Dementia Yes No Relationship					
Receiving Meals on Wheels? Use a Cane, Walker or Wheelchair?				Receiving Meals on Wheels? Use a Cane, Walker or Wheelchair?					
Tobacco Use? Form? Marijuana Use? Form?				bacco Use? I arijuana Use?					
quested Benefit Amount				sted Benefit	Amount				
nefit Period			-						
ietit Perioa			Benet	it Period					

Yes