Ion Financial & Insurance Services

Long Term Care Insurance Division
2106 9th St., Los Osos, CA 93402
CA Insurance License 0E26264
(805) 528-4358
Toll Free: 877-774-1711

LTCI MEDICAL SCREENING QUESTIONNAIRE

Broker: David A. Ion, LUTCF, FSS **Client Name:**_____
Date: _____ **Spouse Applying?** ☐ **Yes** ☐ **No**

A. **What is your age?** ____ - ____ - _____ (00-00-0000) **Weight:** _____ **Height:** _____

Spouses age? ____-____-_____ **Weight:** _____ **Height:** _____

B. **What medications do you take and for what conditions are they prescribed?** (please include diagnosis dates, types of treatment, etc.)_____
_____
_____
_____

C. **Have you ever been treated or diagnosed with cancer?** ☐ Yes ☐ No
Type: _____ Stage / Grade: _____
Date of Diagnosis: _____ Date of Last Treatment: _____
Type of Treatment: _____

D. **Have you ever been treated or diagnosed with any type of diabetes?** ☐ Yes ☐ No
Type:_____ Date of Diagnosis: _____
Current Glucose and/or Hemoglobin A1C Reading: _____
Do you have any of the following?

☐ Tingling, numbness, neuropathy ☐ Visual changes/retinopathy
☐ Skin ulcers, cellulites ☐ TIA / Stroke
☐ Organ damage, kidney, liver problems ☐ Peripheral vascular disease

What medications are you taking for diabetes? (provide dosage specifics) _____
_____
_____

E. **Have you ever been treated or diagnosed with hypertension?** ☐ Yes ☐ No
Current blood pressure reading: _____/_____ Average blood pressure reading: _____/_____
What medications are you taking for hypertension: _____
_____

(Note that if you smoke, based upon your overall health and how it relates to your hypertension, you may or may not be insurable.)

F. **Have you ever been treated or diagnosed with the following heart condition(s)?** ☐ Yes ☐ No

☐ Coronary artery disease, heart attack ☐ Atrial fibrillation
☐ Congestive heart failure ☐ Cardiomyopathy
☐ Valve replacement, valve disease Date of diagnosis: _____

Date and type of treatment: _____
_____

What medications are you taking related to heart condition(s)? (provide dosage amount)

_____

_____

Has your spouse ever been treated or diagnosed with the following heart condition(s)? ☐ Yes ☐ No

☐ Coronary artery disease, heart attack ☐ Atrial fibrillation

☐ Congestive heart failure ☐ Cardiomyopathy

☐ Valve replacement, valve disease Date of diagnosis: _____

Date and type of treatment: _____

_____

What medications is your spouse taking related to heart condition(s)? (provide dosage amount)

_____

_____

G. **Have you ever been treated or diagnosed with chronic obstructive pulmonary disease (COPD), asthma, emphysema?** ☐ Yes ☐ No (If "Yes" and you are a smoker, you may not be eligible for coverage.)

Do you have shortness of breath or dyspnea on exertion? ☐ Yes ☐ No

Are you being treated with oral steroids/Prednisone? ☐ Yes ☐ No If "Yes," dosage? _____

H. **Have you ever had a stroke / TIA / TIA symptoms?** ☐ Yes ☐ No

Date of symptoms/diagnosis: _____

Have you had a recurrence of symptoms? ☐ Yes ☐ No If "Yes," please advise specifics: _____

_____

Do you have any residuals? ☐ Yes ☐ No If "Yes," please advise specifics: _____

_____

I. **Have you ever been treated or diagnosed with osteoporosis / osteopenia?** ☐ Yes ☐ No

Date of diagnosis: _____ Type of treatment: _____

Have you ever had compression fractures due to osteoporosis / osteopenia? ☐ Yes ☐ No If "Yes," please provide specifics: _____

_____

What are your bone mineral density T and /or Z scores? _____

Do you have chronic pain? ☐ Yes ☐ No If "Yes," how is the pain managed? _____

_____

J. **Are you a smoker?** ☐ Yes ☐ No

If "No," have you recently stopped smoking? ☐ Yes ☐ No

How long since you've not smoked? _____ (Years).

Smoking in combination with certain conditions may result in rating or decline.
All insurance coverage's are subject to carriers underwriting.