

Use this form to obtain the medical information required to determine best recommendation for your client.

AGENT _____ PHONE _____ EMAIL _____

PLEASE FAX TO (949) 225-7127 OR email to ltcsales@cpsinsurance.com			
Applicant Name	Marital Status (circle) S M Domestic Partner	Date of Birth	Height / Weight /

Condition	Date occurred	Explanation / Treatment	Date of Last Treatment
Hospitalization or Surgery in past 10 years			
Heart Surgery, Bypass, Angioplasty, Arterial Stints <i>or</i> Other Heart Conditions			
Stroke or TIA ("mini stroke") <i>or</i> Uncontrolled Blood Pressure			
Joint Replacement			
Arthritis Any physical limitations? Medications?			
Osteoporosis Last Bone Density Score? Any falls or fractures? Medications?			
Diabetes Type I – units of insulin? Type II – what oral medications? Last A1C test results?			
Cancer Type and Stage Last Date of Treatment Surgery, radiation, chemo?			
Other Medical Conditions			

Medications	Dosage / Frequency	Reason

1. Do you use tobacco products? Yes How long? _____ Yrs No
2. Are you currently using oxygen, a wheelchair, a walker, or a cane? Yes No
3. Do you need any assistance with activities of daily living? Yes No
4. Do you have any chronic memory loss? Yes No
5. Are you currently receiving physical therapy? Yes No
6. Do you have any surgery scheduled or recommended? Yes No
7. Are you receiving any disability benefits? Yes No