LONG-TERM CARE WORKSHEET

This is a fillable form. If you fill it out electronically - save the file and return it by email.
If you print it out and fill it out manually - scan it and return it by email or fax to 503-467-5567

First Name	M.I.	Last Name	Gender	Birth Date

Birth Place (city & state)	Social Security #	Drivers License #	Occupation & Duties

Home Address	City	State	Zip	Years At Address	Home Phone
Business Name & Address	**City**	**State**	**Zip**	**Years w/employer**	**Business Phone**

1) Height: _____ Weight: _____

2) Are you married? ❑ Yes ❑ No

3) If you are not married, are you in a committed relationship with a Partner or an immediate family member of the same generation, with whom you have been living together for at least the past 3 years? ❑ Yes ❑ No

4) Do you currently have a Long-Term Care insurance Policy,
If Yes, details _____ ❑ Yes ❑ No

5) Have you applied for insurance in the past year? ❑ Yes ❑ No

6) In the past 10 years, have you done or do you intend to do any of the following activities: Skin/scuba diving, Parachuting, Motorized racing, Rock/Mountain climbing Boxing? If yes, frequency: _____ ❑ Yes ❑ No

7) In the past 10 years, have you been convicted of two or more felony motor vehicle violations or had a driving license suspended or revoked? ❑ Yes ❑ No
Details: _____

8) Please list all medications currently prescribed.

Prescription	Dosage	Frequency	Reason

9) Please list the following information regarding your Primary Care Physician & Other Physicians:

Name	Address & Phone Number	Date Last Seen	Reason & Treatment

10) Have you consulted with your primary care physician within the past 18 months? ❑ Yes ❑ No

11) Within the past 10 years, have you had a diagnosis for: ❑ Yes ❑ No

Alzheimer's Disease	Huntington's Chorea	Multiple Sclerosis	Schizophrenia
Amyotrophic Lateral Sclerosis	Memory Loss	Muscular Dystrophy	Scleroderma
Cystic Fibrosis	Mental Retardation	Myasthenia Gravis	Spinal Cord Injury
Dementia	Multiple Myeloma	Parkinson's Disease	Stroke

12) Do you require human assistance or supervision in any of the following activities: eating, dressing, toileting, transferring from bed to chair, walking, maintaining continence, and bathing? ❑ Yes ❑ No

13) Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care? ❑ Yes ❑ No

14) Do you currently use one of the following medical devices: wheelchair, walker, hospital bed, quad cane, oxygen, stairlift, and dialysis? ❑ Yes ❑ No

15) Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex? ❑ Yes ❑ No

16) Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?…… ❑ Yes ❑ No

17) Within the last 10 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions?

a) **Circulatory Disorders:** Transient Ischemic Attack, Amaurosis Fugax, Heart Arrhythmias, Valvular Disease, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Coronary Artery Disease, High Blood Pressure, PeripheralVascular Disease, Carotid Artery Disease, Embolisms……..❑ Yes ❑ No

b) 2. **Endocrine and Pituitary Disorders:** Diabetes, Addison's Disease, Pancreatitis, Cushing's Disease…….. ❑ Yes ❑ No

c) **Cancers:** Leukemia, Lymphoma, Tumors, Melanoma, Squamous Cell, Sarcomas ❑ Yes ❑ No

d) **Genitourinary Disorders:** Renal Insufficiency, Kidney Failure, Incontinence, Prostate Disorders,Bladder Disorders …… ❑ Yes ❑ No

e) **Gastrointestinal Disorders:** Hepatitis, Ulcerative Colitis, Crohn's Disease, Liver Disorders,Cirrhosis ……... ❑ Yes ❑ No

f) **Neurological Disorders:** Cerebral Atrophy**,** Mental Illness, Depression, Seizures, Tremors, Neuropathy, Syncope, Anxiety, Chronic Fatigue Syndrome…... ❑ Yes ❑ No

g) **Blood Disorders:** Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis ……❑ Yes ❑ No

h) **Musculoskeletal Disorders:** Osteoporosis, Arthritis, Rheumatoid Arthritis, Osteoarthritis, Fractures, Fibromyalgia, Degenerative Joint Disease, Scoliosis, Spinal Stenosis, Lupus, Polymyalgia Rheumatica,Osteopenia, Paralysis, Crest…….❑ Yes ❑ No

i) **Respiratory Disorders:** Emphysema, Bronchitis, Asthma, Bronchiectasis, Asbestosis, Sarcoidosis,Chronic Obstructive Pulmonary Disease . . . . . ❑ Yes ❑ No

j) **Eye & Ear Disorders:** Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Labrynthitis, Meniere's/Vertigo…….. ❑ Yes ❑ No

k) **Substance Abuse:** ,Alcoholism, Drug dependency, Illicit drug use……❑ Yes ❑ No

18) Within the last 10 years have you been hospitalized or have you consulted or been treated by a member of the medical profession for any reason not previously stated……❑ Yes ❑ No

19) Within the last 5 years has any surgery or test(s) been recommended that have not been performed?…… ❑ Yes ❑ No

20) Within the past 10 years, have you had an application for life, accident, medical or health, disability or longterm care insurance declined, postponed, modified or rated? ❑ Yes ❑ No
If YES, list medical reason: _____

21) Are you receiving any disability benefits?…… ❑ Yes ❑ No
If YES, list medical reason:_____ Disability %_____

22) Please provide details regarding any "Yes" answers and applicable medical conditions:

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