MEDICAL SCREENING QUESTIONNAIRE

Client's name ______________________________ **Age** ____________

A. Have you ever been treated or diagnosed with Diabetes? ❑ Yes ❑ No

Type: ❑ Insulin dependent (Type I) # units of insulin ____________
❑ Non-Insulin dependent (Type II) *(60 units per day represents a decline)*

Current Glucose and/or Hemoglobin A1C reading ____________ Oral medications ____________

Do you have any of the following? (*These are co-morbid* factors which may result in ratings or declination*)

- Diabetic Retinopathy (eye)
- Diabetic Neuropathy (burning/tingling)
- Kidney Problems (proteinuria)
- Diabetes without current follow up or blood sugars
- Peripheral vascular disease
- Coronary artery disease, heart disease
- Stroke/TIA (mini stroke)
- Tobacco use
- Excessive weight
- Hypertension (high blood pressure)

B. Have you ever been treated or diagnosed with cancer? ❑ Yes ❑ No

Type ____________ Stage/Grade ____________

Date of diagnosis ____________ Date and type of last treatment ____________

If yes, has there been a recurrence? ❑ Yes ❑ No

C. Have you ever been treated or diagnosed with osteoporosis/osteopenia? ❑ Yes ❑ No

Date of diagnosis ____________ Type of treatment ____________

Have you ever had compression fractures/falls due to osteoporosis? ❑ Yes ❑ No

What is most recent bone density test scores? ____________

Do you have chronic pain? ❑ Yes ❑ No

D. Have you ever been treated or diagnosed with COPD (Chronic Obstructive Pulmonary Disease), Asthma, or Emphysema? ❑ Yes ❑ No

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

Are you currently being treated with oral steroids/prednisone? ❑ Yes ❑ No

(**If a smoker, Do Not Complete**)

What is your most recent pulmonary function test scores? ____________

E. Have you ever had a stroke or been diagnosed by a physician with TIA or TIA symptoms? ❑ Yes ❑ No

Date of symptoms/diagnosis ____________

Do you have recurrent symptoms? ____________

Do you have any residuals? ____________

Medication(s), if any ____________

Do you have valve disease, cardiovascular disease, or carotid stenosis? ____________

F. Have you ever been treated or diagnosed with any of the following heart condition(s)?

- Coronary Artery Disease, heart attack
- Valve replacement, valve disease
- Congestive heart failure
- Atrial Fibrillation
- Cardiomyopathy

Type of treatment and date of diagnosis ____________

(*Please contact underwriting to discuss*)

G. Do you have a history of degenerative disc disease with chronic pain? ❑ Yes ❑ No

H. Have you ever discussed any memory issues with your physician (forgetfulness, memory loss, severe depression, or mental disorders)? ❑ Yes ❑ No

(If so, this could result in a rating or declination. Please contact underwriting to discuss)

I. Do you have a history of Rheumatoid Arthritis/Fibromyalgia? ❑ Yes ❑ No

- With Depression may result in ratings or a decline
- 12 months stability period required

Date of symptoms/diagnosis ____________

Any assisted devices needed? (walker, wheelchair, cane)

Medication(s), if any ____________

Is physical therapy required? ❑ Yes ❑ No

Have you had falls/fractures? ❑ Yes ❑ No

J. Have you ever been treated or are you currently being treated for high blood pressure? ❑ Yes ❑ No

Blood pressure controlled with medication could be PREFERRED OR STANDARD RATING. Please contact underwriter.

K. Are you a smoker? ❑ Yes ❑ No

If yes, automatic STANDARD RATING.

(Co-morbid* factors: Emphysema, asthma, chronic bronchitis, heart disease, stroke)

Are you a former smoker? ❑ Yes ❑ No If so, when did you stop? ____________

(Co-morbid refers to the presence of multiple health conditions which, due to their interactions and the increased risk implications when assessed together, rather than assessed separately, may result in a rating or a declination.)

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