Long Term Care Pre Screen Questionnaire

Client Info: *(Complete separate form each proposed insured)*

Name _____ DOB _____ M☐ F☐

Are you a US Citizen Y☐ N☐

Height _____ Weight _____ Married/Partner Y☐ N☐

Have you ever used Nicotine Products? Y☐ N☐

Have you used any Nicotine Product in the last 12 months? Y☐ N☐

Type _____ How Often _____ Date Stopped _____

Do you need assistance or supervision of any kind to perform the following activities?

Eating	Y☐ N☐
Dressing	Y☐ N☐
Bathing	Y☐ N☐
Walking	Y☐ N☐
Getting In and Out of Bed	Y☐ N☐
Taking Medications	Y☐ N☐
Using the toilet	Y☐ N☐
Loss of bowel or bladder Control	Y☐ N☐
Do you ever use a wheelchair, walker, cane or hospital bed	y☐ N☐
Do you have any complaints of Memory loss or forgetfulness	Y☐ N☐

Have you ever been diagnosed or been treated by a member of the medical profession for any of the following?

Alcohol/drug dependency	Y☐ N☐
Nervous, mental or an emotional disorder	Y☐ N☐
Alzheimer's or Parkinson's disease	Y☐ N☐
Cancer or Tumor	Y☐ N☐
Stroke/TIA or Circulation Disorder	Y☐ N☐
Disorder of the Digestive System	Y☐ N☐
Arthritis, Bone or Joint Disorder	Y☐ N☐
Bronchitis, Asthma, or other disorder of the respiratory system	Y☐ N☐
Medical diagnosis of AIDS or ARC	Y☐ N☐
Diabetes – if yes Date of onset _____ Insulin Dependent?	Y☐ N☐
Y☐ N☐ #of units per day _____	
Have you been hospitalized within the last 24 months	Y☐ N☐

List ALL Medications you are taking:

Name	Dosage	Times Per Day

Details to ALL YES Answers and additional info:

Agent Name _____

Phone _____ EMAIL _____

Email completed form to RampartInfo@rampartlife.com