



Long Term Care Insurance Medical History Form

Please print legibly. If spouses are both applying, please complete a form for each client.
Should you need to provide more details on any medical conditions, please attach additional sheets.

Date: _____

AGENT INFORMATION

Name: _____ Telephone: _____ Fax: _____
Email: _____

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Resident State: _____ Marital Status: _____
Height: _____ Weight: _____ Gender: Male Female
Smoker: Yes No If client has quit smoking, how long has it been since last use?: _____
Medical Condition: _____ Date of Onset: _____
Medical Condition: _____ Date of Onset: _____
Medical Condition: _____ Date of Onset: _____
Medical Condition: _____ Date of Onset: _____

CURRENT MEDICATIONS AND HOSPITALIZATION HISTORY

Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____
Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____
Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____
Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____
Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____
Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____
Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____

Date of Hospitalization: _____ to _____ Reason: _____
Result: _____

Date of Hospitalization: _____ to _____ Reason: _____
Result: _____

Date of Hospitalization: _____ to _____ Reason: _____
Result: _____

Date of Hospitalization: _____ to _____ Reason: _____
Result: _____

Special Notes: _____



Please FAX to: (210) 341-7909

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