



# 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: \_\_\_\_\_

If you have additional questions, please contact CBS Brokerage at 763.450.1870.

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