LIFE SETTLEMENT HEALTH QUESTIONNAIRE

Insurance company_____Policy number _____

Insured Name_____

Height_____Weight_____Social security number_____Date of birth_____ Gender_____

MM/DD/YYYY

1. Do you live in one of the following? (assisted living facility, skilled nursing facility or nursing home, other)

_____ If yes, approximately how long have you lived there?

_____

2. Do you require assistance to perform any of the following activities? *(meal planning, taking medication, shopping, walking, bathing, dressing)*

If yes, provide details regarding why assistance is needed _____

3. After you fall asleep at night, on average, how many times (if any) do you typically get up? _____

4. Do you drive? If no, provide year and reason you stopped driving _____

_____

5. Approximately how often do you see your primary care physician? _____

6. Approximately how often do you see specialists, such as a cardiologist or orthopedist? _____

7. Are you currently choosing not to see doctor(s) or choosing not to follow a doctor's instruction? If yes, provide details

_____

8. Has your weight changed in the last year? If yes, provide details _____

9. Do you engage in sports or regular exercise? If yes, provide type and frequency _____

10. Have you ever smoked cigarettes? _____

If you currently smoke or previously smoked, provide number of years_

_____cigarettes per day _____

If you quit smoking, approximately how many years ago did you quit? _____

11. Do you use any other form of tobacco or nicotine? _____

If yes, provide type and frequency _____

12. Do you drink alcoholic beverages? _____

If yes, provide type and frequency _____

Have you ever been diagnosed with OR treated for any of the following conditions?
(Please check all that apply and provide details at the end of section four on page three.)

1. Disease or disorder of the heart?

_____

_____

2. Circulatory or Blood Vessel Disorder?

_____

_____

3. Cancer? (not including non-melanoma minor skin cancer)

_____

_____

4. Neurological Disorder?

_____

_____

5. Mental or Nervous Disorder?

_____

_____

6. Disease or Disorder of the Digestive System?

_____

_____

7. Infectious Disease? (other than common cold or flu)

_____

_____

8. Disease or Disorder of the Lungs or Respiratory System?

_____

_____

9. Genitourinary Problems, Disease or Disorder?

_____

_____

10. Abnormality of the Blood, Platelets or Blood Forming Organs?

_____

_____

11. Bone, joint or nerve Abnormality, Injury or Accidental Fall?

_____

_____

12. Immune System Disorder?

_____

_____

13. Alcohol and Drug Use?

_____

_____

14. Have you ever had a transplant of any organ or tissue, been diagnosed with, been treated for, had surgery, or are currently being treated for any other disease or disorder, or had an accident or injury not previously listed?

_____

_____

15. Other Conditions Not Listed?

_____

_____

16. Health Screen History (if known)

Blood Pressure _____ Blood Tests: Cholesterol _____ Blood Sugar _____ Ejection Fraction _____

For any condition checked above, please provide full details including diagnosis, date of diagnosis, type of treatment(s) received, date last treated, results and additional details. *(Please attach additional page(s) as necessary.)*

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY

Type of treatment received _____ Date last treated _____ MM/DD/YYYY

Results _____

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY

Type of treatment received _____ Date last treated _____ MM/DD/YYYY

Results _____

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY

Type of treatment received _____ Date last treated _____ MM/DD/YYYY

Results _____

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY

Type of treatment received _____ Date last treated _____ MM/DD/YYYY

Results _____

Family History (Include full and half siblings.)

	Age, if living	Age at death, if deceased	Cause of death	
Mother	_____	_____	_____	
Father	_____	_____	_____	
Sibling	_____	_____	_____	Gender_____
Sibling	_____	_____	_____	Gender_____
Sibling	_____	_____	_____	Gender_____
Sibling	_____	_____	_____	Gender_____
Spouse	_____	_____	_____	Gender_____

Prescription Medications

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Physician Information

1. Primary Care Physician

   Name_____Phone _____

   Address_____City_____State_____ ZIP_____

   Approximate date of last visit_____Reason for last visit _____
   MM//YYYY

2. Specialty Care Physicians

   List those who have treated you in the last five years. *(Please attach additional page(s) as necessary.)*

   Name_____Phone _____

   Physician Specialty _____

   Address_____City_____State_____ ZIP_____

   Approximate date of last visit_____Reason for last visit _____
   MM//YYYY

   Name_____Phone _____

   Physician Specialty _____

   Address_____City_____State_____ ZIP_____

   Approximate date of last visit_____Reason for last visit _____
   MM//YYYY

   Name_____Phone _____

   Physician Specialty _____

   Address_____City_____State_____ ZIP_____

   Approximate date of last visit_____Reason for last visit _____
   MM//YYYY

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Name of insured | Signature of insured | Date