Planner / Broker Name:_____
Address:_____
Phone Number:_____ Fax _____

Long-Term Care Planning
Health Information Request Form

Client Name:_____
D/O/B_____ Ht._____ Wt._____
Smoker_____Marital Status_____

Any Medical History of:

_____Osteoporosis ____M.S.
_____Stroke ____TIA
_____Alzheimer's ____Memory Loss
_____Parkinson's _____Insulin Dependant Diabetes

Client Medical History Last 10 years:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Prescriptions being taken:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Spuse Name:_____
D/O/B_____ Ht._____ Wt._____
Smoker_____Marital Status_____

Any Medical History of:

_____Osteoporosis ____M.S.
_____Stroke ____TIA
_____Alzheimer's ____Memory Loss
_____Parkinson's _____Insulin Dependant Diabetes

Spouse Medical History Last 10 years:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Prescriptions being taken:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____