

Advisor Name: _____

Phone Number: _____ **Email:** _____

Name: _____ **Spouse, if married:** _____

Date of Birth: _____ **Spouse's DOB:** _____

State: _____

Pre-Screening Health Statement - Part A

	Client		Spouse (if applicable)	
	Yes	No	Yes	No
1. Within the past two years have you been confined to a nursing home, assisted living center, received or been advised to receive hospice care, been advised that you have a terminal illness or need assistance with: bathing, eating, dressing, toileting, transferring into and out of bed, chair, or wheelchair and/or maintain continence?				
2. Are you currently hospitalized, bedridden or use medical devices such as: wheelchair, walker, dialysis machine, oxygen equipment, respirator, stair lift, chair lift, motorized scooter or taking medications Aricept, Exelon, Reminyl or Namenda?				
3. Have you ever been diagnosed by a member of the medical profession as having AIDS, HIV, or ARC disorders, or tested positive for antibodies for the AIDS virus?				
4. If under the age of 65, is there any reason you are not physically and mentally capable of active employment or are you currently receiving or have received within the past five years social security disability income benefits?				
5. Have you ever been diagnosed, treated, tested positive for, or been given professional medical advice for: Alzheimer's disease, dementia, memory loss, multiple sclerosis, muscular dystrophy, ALS (Lou Gehrig's disease) Parkinson's disease, down syndrome, organ transplant (other than kidney) or active cancer?				

Client: _____ **Height:** _____ **Weight:** _____

In the past 5 years, is there a history of:

- | | | | |
|----------------------------------|--------------------------|-----------------------------------------|----------------------------------------------|
| Diabetes | Leukemia | Heart Attack | Chronic Obstructive Pulmonary Disease (COPD) |
| Depression | Heart Disease | Cardiomyopathy | Stroke |
| Uncontrolled High Blood Pressure | Congestive Heart Failure | Amyotrophic Lateral Sclerosis (ALS) | |
| Cancer | Organ Failure/Disease | Chronic Obstructive Lung Disease (COLD) | |

IF ABOVE CHECKED PLEASE PROVIDE DETAILS ON NOTES PAGE

Other: _____

Medication	DOSE	FREQUENCY	REASON

Spouse: _____ **Height:** _____ **Weight:** _____

In the past 5 years, is there a history of:

- | | | | |
|----------------------------------|--------------------------|-----------------------------------------|----------------------------------------------|
| Diabetes | Leukemia | Heart Attack | Chronic Obstructive Pulmonary Disease (COPD) |
| Depression | Heart Disease | Cardiomyopathy | Stroke |
| Uncontrolled High Blood Pressure | Congestive Heart Failure | Amyotrophic Lateral Sclerosis (ALS) | |
| Cancer | Organ Failure/Disease | Chronic Obstructive Lung Disease (COLD) | |

IF ABOVE CHECKED PLEASE PROVIDE DETAILS ON NOTES PAGE

Other: _____

Medication	DOSE	FREQUENCY	REASON

Monthly Income:

Type	Client Income	Spouse Income
Social Security		
Gross Wages		
Pensions		
Other		
Total		

Do you rely on IRA Income for living expenses? **Yes** **No**