Client Health Questionnaire

CLIENT NAME	DATE OF BIRTH	NICOTINE USAGE	HEIGHT	WEIGHT
#1:		☐ NO ☐ YES		
#2:		☐ NO ☐ YES		

HEALTH STATUS & HISTORY

IN THE PAST 10 YEARS HAVE YOU RECEIVED MEDICAL ADVICE, TREATMENT, DIAGNOSIS OR CONSULTATION FOR ANY OF THE FOLLOWING CONDITIONS?

	CLIENT 1	CLIENT 2
Cancer (other than skin) *	☐	☐
Cardiac/Coronary Issues *	☐	☐
Diabetes *	☐	☐
Alcoholism or Drug Addiction	☐	☐
Alzheimer's	☐	☐
Amputation	☐	☐
Asthma, COPD or Emphysema	☐	☐
Atrial Fibrillation	☐	☐
Brain Disorder	☐	☐
Chronic Bronchitis	☐	☐

	CLIENT 1	CLIENT 2
Depression or Mental Disorder	☐	☐
Disabling back condition	☐	☐
Epilepsy / Seizures	☐	☐
Fainting Spells	☐	☐
Hodgkin's Disease	☐	☐
Injury due to fall/balance	☐	☐
Joint Replacement Surgery	☐	☐
Multiple Sclerosis	☐	☐
Organ Transplant	☐	☐
Osteoporosis	☐	☐

	CLIENT 1	CLIENT 2
Paralysis	☐	☐
Parkinson's / Tremors	☐	☐
Rheumatoid Arthritis	☐	☐
Spine Condition	☐	☐
Strokes / TIAs	☐	☐
Tuberculosis (TB)	☐	☐
Other condition causing crippling / disability	☐	☐
Other conditions causing limited motion	☐	☐
Other conditions requiring adaptive devices	☐	☐
Other: _____	☐	☐

** SEE PAGE TWO FOR REQUIRED MEDICAL INFORMATION NECESSARY TO ASSESS THESE ISSUES/CONDITIONS*

Please provide details below for <u>all</u> medications taken (including over-the-counter) with the prescription name, reason prescribed, dosage and frequency. Additionally, please provide details for any questions answered "YES" along with information for any scheduled doctor visits, surgery, therapy or treatments

CLIENT #1	CLIENT #2

Authorization To Disclose Personal Medical Information

Under applicable state & federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), I give INERTIA / Advisor Services Group, and its agents/representatives access to and use of my protected health information for the purposes of the underwriting or administration of insurance coverage on my behalf. The information used in accordance with this authorization may be redisclosed by INERTIA, and may no longer be protected by federal and state privacy laws.

- *By signing this form, I agree to the release, disclosure, and sharing of my medical information by INERTIA and its agents and I relieve them from all liability having to do with that disclosure. This authorization will expire 24 months from the date of your signature. (Only valid for one year in CT, GA, IL, MA, MN, NC, NJ, OH, and OR). I am entitled to a copy of this authorization form and a digital copy of this authorization is as valid as the original.*
- *I have the right to revoke this authorization, in writing, at any time but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health and non-health information taken before receipt of the revocation notice.*

Signatures of insured, applicant, annuitant, claimant or legal representative	Date	Applicable State(s)	Phone Number
_____	_____	_____	_____

Cardiac / Coronary Issues

Date of diagnosis/onset of chest pain: _____

Number of involved vessels _____

Dates and details of treatment and/or surgery (e.g., angioplasty, bypass, etc.)

_____

_____

Date of last testing (EKG, stress, stress echo, etc.): _____

Results: _____

_____

Any symptoms since treatment/surgery: _____

Cancer

Name/diagnosis and location: _____

_____

Date of diagnosis: _____

Stage/Grade/Metastasis: _____

_____

Dates/details of treatment and/or surgery: _____

_____

Any recurrence: _____

Date of last follow-up: _____

Diabetes

Date of diagnosis: _____ Type ☐ I or ☐ II

Treatment: ☐ Insulin ☐ Diet ☐ Medications

List insulin dosage and/or medications: _____

_____

Date/result of last A1c: _____

Has proposed insured been diagnosed with any of the following:

☐ Retinopathy ☐ Kidney Disease ☐ Neuropathy

☐ Heart Disease ☐ Hypertension ☐ Insulin Reaction

☐ Cerebrovascular/Peripheral Vascular Disease ☐ Urine Protein/Microalbumin