



LTCI Case Development Worksheet Medical Questionnaire

AGENT _____ PHONE _____ CLIENT _____

HEIGHT _____ WEIGHT _____ DATE LAST SMOKED: _____ (Never)

Have you been hospitalized, and/ or received physical therapy in the last 5 years?

___ Yes ___ No Dates _____ For what? _____

Details: _____

What prescription medicines are you taking now?

_____ Dosage _____ for? _____
_____ Dosage _____ for? _____
_____ Dosage _____ for? _____
_____ Dosage _____ for? _____

Have you ever been treated for any of the following?

Heart conditions: ___ Y ___ N **Depression:** ___ Y ___ N **Cancer:** ___ Y ___ N

Osteoporosis: ___ Y ___ N **Stroke/TIA:** ___ Y ___ N **Asthma:** ___ Y ___ N

Cognitive impairment: ___ Y ___ N What kind/how long? _____

Diabetes: ___ Y ___ N When diagnosed: _____; Last blood sugar/A1C reading? _____
and Date obtained? _____; Any sight, circulation, or other related problems? _____

Assistance of any kind walking or standing up: ___ Y ___ N Details: _____

OTHER Medical Information: _____

Explain Yes answers above: _____

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