PERSONAL PROFILE FORM

Date _____ How did you hear about our service? _____

Demographic Information

Name _____ Sex M F

Address _____

City _____ State _____ Zip _____

Telephone H / W / C _____ Fax _____

E-mail address: _____

Date of Birth _____ Married? Y N Spouse Applying? Y N

Spouse's Name _____ Spouse's Date of birth _____

Health Screening Questionnaire

In order to better serve you, we need you to first complete this health screening questionnaire. You may return by *fax at: 312-977-0128* or mail to Burling Insurance Group 55 West Wacker Dr. Suite 1400, Chicago, IL 60601.

1. Overall how do you classify your health? ..... Excellent ☐ Good ☐ Fair ☐ Poor ☐

2. What is your height and weight? _____

3a. Do you currently have, or have you ever had a diagnosis for:

Alzheimer's disease	Huntington's Chorea	Multiple Sclerosis	Schizophrenia
Amyotrophic Lateral Sclerosis	Memory Loss	Muscular Dystrophy	Scleroderma
Cystic Fibrosis	Mental Retardation	Myasthenia Gravis	Spinal Cord Injury
Dementia	Multiple Myeloma	Parkinson's disease	Stroke/CVA ..... ☐ Yes ☐ No

3b. Do you require human assistance or supervision in any of the following activities: eating, dressing, toileting, transferring from bed to chair, walking, maintaining continence and bathing? ..... ☐ Yes ☐ No

3c. Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care? ..... ☐ Yes ☐ No

3d. Do you currently use one of the following medical devices: wheelchair, walker, hospital bed, quad cane, Oxygen, stair lift, and dialysis? ..... ☐ Yes ☐ No

3e. Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex? ..... ☐ Yes ☐ No

4a. Have you consulted with your primary care physician within the past 18 months? ..... ☐ Yes ☐ No

Primary Care Physician Name: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

4b. Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months? ☐ Yes ☐ No

4c. Within the last 10 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions?

1. **Circulatory Disorders**: Transient Ischemic Attack, Amaurosis Fugax, Heart Arrhythmias, Valvular Disease, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Coronary Artery Disease, High Blood Pressure, Peripheral Vascular Disease, Carotid Artery Disease, Embolisms ……. ☐ Yes ☐ No
2. **Endocrine and Pituitary Disorders**: Diabetes, Addison's Disease, Pancreatitis, Cushing's Disease ... ☐ Yes ☐ No
3. **Cancers**: Leukemia, Lymphoma, Tumors, Melanoma, Squamous Cell, Sarcomas ……..……..... ☐ Yes ☐ No
4. **Genitourinary Disorders**: Renal Insufficiency, Kidney Failure, Incontinence, Prostate Disorders, Bladder Disorders …….. ☐ Yes ☐ No
5. **Gastrointestinal Disorders**: Hepatitis, Ulcerative Colitis, Crohn's Disease, Liver Disorders, Cirrhosis … ☐ Yes ☐ No
6. **Neurological Disorders**: Cerebral Atrophy, Mental Illness, Depression, Seizures, Tremors, Neuropathy, Syncope, Anxiety, Chronic Fatigue Syndrome ……..……... ☐ Yes ☐ No
7. **Blood Disorders**: Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis …….. ☐ Yes ☐ No
8. **Musculoskeletal Disorders**: Osteoporosis, Arthritis, Rheumatoid Arthritis, Osteoarthritis, Fractures, Fibromyalgia, Degenerative Joint Disease, Scoliosis, Spinal Stenosis, Lupus, Polymyalgia Rheumatica, Osteopenia, Paralysis, Crest ……. ☐ Yes ☐ No
9. **Respiratory Disorders**: Emphysema, Bronchitis, Asthma, Bronchiectasis, Asbestosis, Sarcoidosis, Chronic Obstructive Pulmonary Disease ……. ☐ Yes ☐ No
10. **Eye & Ear Disorders**: Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Labrynthitis, Meniere's Vertigo ……. ☐ Yes ☐ No
11. **Substance Abuse**: Alcoholism, Drug dependency, Illicit drug use ……..……..…… ☐ Yes ☐ No

4d. Within the last 10 years have you been hospitalized or have you consulted or been treated by a member of the medical profession for any reason not previously stated? ……... ☐ Yes ☐ No

4e. Within the last 5 years has any surgery or test(s) been recommended that have not been performed? ☐ Yes ☐ No

4f. Have you ever had an application for life, accident, medical or health, disability or long-term care Insurance declined, postponed, modified or rated? …….. ☐ Yes ☐ No

4g. Are you receiving any disability benefits? ……..……..…… ☐ Yes ☐ No

4h. Are you currently receiving any physical therapy, or have you received any physical therapy within the last 3 months?……..…… ☐ Yes ☐ No

4i. MEDICAL HISTORY DETAILS – If you answered YES to any questions 4c through 4h provide full detail here.

Question #	Diagnosis, Disorder, and/or Reason	Diagnosis Date	Treatment Date	Explanation or Comments

4j. Are you currently taking any medications, or discontinued any medications within the past 6 months?…..☐ Yes ☐ No
If yes, for what conditions and what dosage?

Medication	Dosage	Start Date	Discontinue Date	Condition