Health and Lifestyle Questionnaire

Answer the following questions if you will be 69 or older the date policy will be effective

Personal Information

Please provide your height and weight to help us better understand your health profile. Enter your height in feet and inches and your weight in pounds in the spaces below.
Height: ____ ft. ____ in. **Weight**: _____ lbs.

Tobacco and Nicotine Use

In the past 12 months, have you used any form of tobacco, electronic cigarettes, or other nicotine products? Please indicate your answer by checking one of the following options: **Yes ___No ____**

Medical History

For each of the following medical conditions or situations, please indicate "Yes" or "No" as appropriate. These questions refer to your health status within the past 24 months unless otherwise specified.
Have you had, been treated for, or been told by a medical professional that you have any of the following?

Chronic kidney disease (stages 3, 4, or 5); kidney failure; or kidney disease requiring dialysis **Yes ___No __**

Internal cancer, including cancer that requires surveillance or is in remission within the past two years; blood cancers such as leukemia, lymphoma, or melanoma; or if you have undergone any non-routine medical test to rule out or confirm cancer that is not yet completed **Yes ___No __**

Diabetes requiring insulin use, or diabetes in combination with heart disease (excluding high blood pressure) **Yes __No____**

Arthritis that restricts mobility or daily activities, requires physical therapy, requires major joint injections (hip, knee, shoulder), or for which you have been advised to have a joint replacement; Rheumatoid Arthritis **Yes ___No___**

Liver disease, cirrhosis, alcoholism, or drug abuse **Yes ___No___**

Bipolar disease, schizophrenia, or any other psychotic disorders **Yes ___No___**

Use of drugs administered by intravenous (IV) infusion, except during an emergency room visit, hospitalization, or surgery **Yes ___No___**

Do you use oxygen as treatment for a diagnosed medical condition? **Yes ___No___**

Have you been admitted to the hospital within the past three months? **Yes ___No___**

Has a medical professional advised or discussed as a treatment option that you may need surgery (including cataract surgery) or drugs administered by intravenous (IV) infusion? **Yes ___No___**

Do you have or have you experienced any of the following conditions?

Coronary artery disease; heart attack; heart surgery (including angioplasty, heart stent, or bypass) **Yes ___No___**

Congestive heart failure; cardiomyopathy; heart valve disorder; atrial fibrillation or other heart rhythm disorders; implanted cardiac defibrillator; pulmonary hypertension; unoperated aneurysm; peripheral vascular disease **Yes ___No___**

Stroke; transient ischemic attack (TIA); carotid artery disease; cerebrovascular disease **Yes ___No___**

Osteoporosis with fracture; degenerative bone disease; amputation or fracture caused by disease **Yes ___No___**

Health and Lifestyle Questionnaire

Answer the following questions if you will be 69 or older the date policy will be effective

Chronic obstructive pulmonary disease (COPD); chronic bronchitis; emphysema; or any chronic pulmonary disorder **Yes ___No___**

Myasthenia Gravis; Grave's Disease; systemic lupus erythematosus (SLE) **Yes ___No___**

Multiple Sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease **Yes ___No___**

Alzheimer's Disease; dementia; or any other cognitive disorder **Yes ___No___**

Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and/or AIDS Related Complex (ARC) **Yes ___No___**

Have you been hospitalized or confined to a nursing home or assisted-living facility within the past 90 days, or have you been hospitalized two or more times in the past 12 months? **Yes ___No___**

Are you confined to a bed, or do you require the use of a wheelchair or any motorized mobility device? **Yes ___No___**

Have you had or been recommended to have an organ or stem cell transplant (excluding cornea transplants)? **Yes ___No___**

Has a medical professional advised or discussed as a treatment option that you may need a non-routine medical procedure within the next 12 months? **Yes ___No___**

If you have both high blood pressure and diabetes, is any of the following true?

You take three or more medications for either condition **Yes ___No___**

Your dosage was increased, or medication was added for either condition in the past two years **Yes ___No___**

You have diabetic complications such as peripheral neuropathy or diabetic retinopathy **Yes ___No___**

Current Medications

Please indicate if you are currently taking any of the following medications by circling all that apply:

Abilify **Advair** **Benlysta** **Breo Ellipta** **Carbidopa-levodopa** **Digoxin**

Embrel **Flecainide** **Flolan** **Humira** **Imuran** **Methotrexate**

Nitroglycerin (or Isosorbide Mononitrate) **Oxygen (from a tank)** **Reclast** **Saphnelo**

Seroquel **Sinemet** **Symbicort** **Tepezza** **Trelegy Ellipta** **Quinidine** **Veletri**

Voclosporin **Xeljanz**

IV Infusion (including but not limited to: **Imuran, Interferon, Remicade, Remodulin, Rituximab, Soliris**)

Insulin (including but not limited to: **Apidra, Humalog, Humulin, Lantus, Levemir, Novolin, Novolog**)

Aricept (or other memory-enhancing drugs live, but not limited to: **Namenda, Razadyne, Exelon**)

Blood thinner (oral or injection including but not limited to: **Coumadin, Eliquis, Heparin, Pradexa, Warfarin, Xarelto**)