












Client Fact Finder

Client Full Name:	
Date of Birth:	
Social Security:	
Phone(s):	
Address	
Male/Female	
Height:	Weight:
Marital Status:	


Y / N	US citizen or legal permanent resident?	
Y / N	Been declined for life, health or long term care insurance?	
Y / N	Have you had or been advised by a member of the medical profession to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less?	
Y / N	Do you use any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted?	
Y / N	Been confined three or more times to a hospital, nursing facility, convalescent care facility, assisted living facility, or mental care facility?	
Y / N		HIV / AIDS
Y / N		Cancer
Y / N		Coronary / Heart Disease / Liver / Kidney Disease
Y / N		Diabetes
Y / N		Respiratory / Lung Disease
Y / N		Mental Impairment
Y / N		Physical Impairment

Y / N		Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?
Y / N		Within the last 3 years have you been diagnosed by a member of the medical profession with Leukemia, lymphoma, melanoma or any internal cancer, or received chemotherapy, radiation or had surgery for any cancer (other than basal or squamous cell cancer of the skin)?
Y / N		Been diagnosed by a member of the medical professional has having more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer) or an amputation caused by cancer or any other disease or are you currently being treated by a member of the medical profession for cancer or recurrence of cancer?

Exact name and location of cancer:	
Stage and grade:	
Dates / details of treatment / surgery	
Doctor who has pathology report:	

	Have you even been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
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Y / N	Heart disease, heart attack, uncontrolled high blood pressure, heart or circulatory surgery, including coronary artery bypass, angioplasty, cardiac or vascular stent placement, pacemaker, or pacemaker replacement, heart valve replacement, abdominal aortic aneurysm, or any procedure to improve the circulation to the heart, brain or extremities?
Y / N	Congestive heart failure, cardiomyopathy, cirrhosis of the liver, liver failure, kidney(renal) failure, end stage kidney disease, chronic kidney disease or renal insufficiency?

	Have you been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:
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Y / N	Diabetes prior to age 20?
Y / N	Taken insulin prior to age 40?
Y / N	Been diagnosed or treated for insulin shock or diabetic coma?
Y / N	Been hospitalized two or more times for any diabetic complications within the last 2 years?

Treatment:	Diet Only	Oral Medication	Insulin
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Latest result of A1C test:	
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	With in the last 2 years have you:
Y / N	Been diagnosed or treated by a member of the medical profession for, been hospitalized for, taken or been prescribed medication for: Chronic Obstructive Pulmonary or Lung disease (COPD/COLD) emphysema, chronic bronchitis, respiratory failure, chronic hepatitis, liver disease, angina, stroke, transient ischemic
	Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
Y / N	Alzheimer's disease, dementia, memory loss, mental incapacity, schizophrenia, manic depression, bipolar disorder, brain disease?
	Have you even been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
Y / N	Cerebral palsy, Parkinson's disease, gran mal epilepsy, systemic lupus, (SLE) disease, or do you have paralysis of 2 or more extremities?
Y / N	Lou Gehrig's disease (ALS), Huntington's disease, muscular dystrophy, cystic fibrosis, multiple sclerosis or multiple myeloma?
With in the last 2 years have you:	
Y / N	Been convicted of a felony or are you currently on parole or on probation?
Y / N	Been treated, diagnosed, or advised to have treatment by a medical professional for alcohol abuse or Drug abuse, or attempted suicide?
Y / N	Within the last 3 years have you been convicted of operating a vehicle while intoxicated, impaired, or under the influence or for reckless driving?
Y / N	Do you exercise regularly (walking, swimming, aerobics, strength training, yoga)? If YES, give details of type, frequency and length of time.
Y / N	Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, pipe, chewing tobacco, nicotine patches or gum)? If YES, give details of type of nicotine product, amount and frequency, and date last used.
Y / N	Do you expect to travel outside of the U.S. or Canada or change your country of residence in the next two years? If YES, give details of location (city/country), purpose, frequency and duration.
Y / N	Have you flown as a student pilot, licensed pilot or crew member in any aircraft, including ultralight planes in the past two years? If YES, please be prepared to complete an aviation questionnaire.
Y / N	Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing or any other hazardous activities in the past two years? If YES, please be prepared to complete an avocation questionnaire.

Physician Name:	
Date last seen:	
Phone Number:	
Address:	
Reason:	

Hospital Name /Clinic Name:	
Physician Name:	
Date last seen:	
Phone Number:	
Address:	
Reason:	

List all Medications, including dose:
