Employee and Family Medical Questionnaire

Section 1: Employer/Employee Information

Employer Name: _____

Names of Family Members Applying for Coverage	Relationship	Date of Birth	Gender Male/Female	Height (feet, inches)	Weight (pounds)
	Employee				
	Spouse				
	Dependent				
	Dependent				
	Dependent				

Section 2: Family Health History

Within the past five (5) years has a physician or other licensed healthcare practitioner ("practitioner") diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment? Use an "X" to mark "YES" or "NO" in the boxes heading each category of conditions below **and** mark with an "X" any of the following conditions that apply.

For all "YES" answers and conditions that you mark with an "X", provide details in the table on the next page.

A. Heart/Circulatory ☐ YES ☐ NO

- ☐ A1. Anemia
- ☐ A2. Angina
- ☐ A3. Angioplasty/Stent
- ☐ A4. Aneurysm
- ☐ A5. Blood Clots
- ☐ A6. Blood Disorder
- ☐ A7. Bypass
- ☐ A8. Cardiac Arrhythmia
- ☐ A9. Chest Pain
- ☐ A10. Congestive Heart Failure
- ☐ A11. Coronary Heart Disease
- ☐ A12. Heart Murmur
- ☐ A13. Hemophilia
- ☐ A14. High/Low Blood Pressure
- ☐ A15. High Cholesterol
- ☐ A16. Pacemaker
- ☐ A17. Palpitations
- ☐ A18. Sickle Cell Anemia
- ☐ A19. Stroke/TIA
- ☐ A20. Varicose Veins
- ☐ A21. Ventricular Tachycardia
- ☐ A22. Other (_____)

B. Eyes/Ears/Nose/Throat ☐ YES ☐ NO

- ☐ B1. Acoustic Neuroma
- ☐ B2. Cataracts
- ☐ B3. Chronic Sinusitis
- ☐ B4. Cleft Lip/Palate
- ☐ B5. Detached Retina
- ☐ B6. Deviated Septum
- ☐ B7. Ear Infections
- ☐ B8. Glaucoma
- ☐ B9. Retinopathy
- ☐ B10. Other (_____)

C. Immune ☐ YES ☐ NO

- ☐ C1. ALS
- ☐ C2. AIDS
- ☐ C3. HIV+
- ☐ C4. Immuno Deficiency
- ☐ C5. Lupus
- ☐ C6. Psoriasis
- ☐ C7. Scleroderma

D. Cancer/Tumors ☐ YES ☐ NO

- ☐ D1. Brain
- ☐ D2. Breast
- ☐ D3. Colon
- ☐ D4. Cyst
- ☐ D5. Hodgkin's Disease
- ☐ D6. Leukemia
- ☐ D7. Liver
- ☐ D8. Lung
- ☐ D9. Lymphoma
- ☐ D10. Melanoma
- ☐ D11. Ovarian
- ☐ D12. Pituitary
- ☐ D13. Prostate
- ☐ D14. Stomach
- ☐ D15. Testicular
- ☐ D16. Thyroid
- ☐ D17. Other (_____)
- ☐ D18. Stage of Cancer if known_____

E. Neurological ☐ YES ☐ NO

- ☐ E1. Alzheimer's Disease
- ☐ E2. Cerebral Palsy
- ☐ E3. Epilepsy
- ☐ E4. Head Injury
- ☐ E5. Migraines
- ☐ E6. Multiple Sclerosis
- ☐ E7. Neuritis
- ☐ E8. Paralysis/Hemiplegia
- ☐ E9. Parkinson's Disease
- ☐ E10. Seizures/Convulsions
- ☐ E11. Other (_____)

F. Transplants ☐ YES ☐ NO

- ☐ F1. Pending
- ☐ F2. On Waiting List
- ☐ F3. Completed Transplant
- ☐ F4. Bone Marrow
- ☐ F5. Stem Cell
- ☐ F6. Organ (Type: _____)

G. Arthritis ☐ YES ☐ NO

- ☐ G1. Arthritis
- ☐ G2. Osteoarthritis
- ☐ G3. Rheumatoid Arthritis

H. Bones/Muscles/Joints ☐ YES ☐ NO

- ☐ H1. Bulging/Herniated Disk
- ☐ H2. Carpal Tunnel Syndrome
- ☐ H3. Fibromyalgia/CFS
- ☐ H4. Fractures (Open or Closed)
- ☐ H5. Gout
- ☐ H6. Joint Replacement(Type:_____)
- ☐ H7. Knee
- ☐ H8. Muscular Dystrophy
- ☐ H9. Neck/Back
- ☐ H10. Shoulder
- ☐ H11. Spina Bifida
- ☐ H12. Sprain/Strain
- ☐ H13. Other (_____)

I. Psychological ☐ YES ☐ NO

- ☐ I1. ADD/ADHD
- ☐ I2. Alcoholism
- ☐ I3. Anxiety
- ☐ I4. Autism
- ☐ I5. Bipolar
- ☐ I6. Depression
- ☐ I7. Drug Abuse
- ☐ I8. Eating Disorder
- ☐ I9. Schizophrenia
- ☐ I10. Suicide Attempt
- ☐ I11. Other (_____)

J. Diabetes/Endocrine ☐ YES ☐ NO

- ☐ J1. Diabetes controlled by:
  - ☐ a. Diet
  - ☐ b. Oral Medication
  - ☐ c. Insulin
  - ☐ d. Other (_____)
- ☐ J2. Adrenal Glands
- ☐ J3. Growth Hormones
- ☐ J4. Hyperthyroidism/Hypothyroidism
- ☐ J5. Other (_____)

K. Reproductive ☐ YES ☐ NO

- ☐ K1. Breast Disorder
- ☐ K2. Endometriosis
- ☐ K3. Fibroids
- ☐ K4. Menstrual Disorder
- ☐ K5. Ovarian Cysts

L. Lung/Respiratory ☐ YES ☐ NO	M. Intestinal ☐ YES ☐ NO	N. Liver/Kidney/Urinary ☐ YES ☐ NO
☐ L1. Allergies	☐ M1. Acid Reflux/GERD	☐ N1. Bladder Disorder
☐ L2. Asthma	☐ M2. Colitis/IBS	☐ N2. Cirrhosis
☐ L3. COPD (On Oxygen? _____)	☐ M3. Colon Disorder	☐ N3. Gaucher's Disease
☐ L4. Cystic Fibrosis	☐ M4. Crohn's Disease	☐ N4. Hepatitis (Type: _____)
☐ L5. Emphysema	☐ M5. Diverticulitis/Diverticulum	☐ N5. Jaundice
☐ L6. Lung Disorder	☐ M6. Gallbladder	☐ N6. Kidney Disorder
☐ L7. Pneumonia	☐ M7. Gastric Bypass	☐ N7. Kidney Stones
☐ L8. Sarcoidosis	☐ M8. Hiatal Hernia/Reflux	☐ N8. Liver Disorder
☐ L9. Sleep Apnea	☐ M9. Pancreatitis	☐ N9. Polycystic Kidney
☐ L10. Tuberculosis	☐ M10. Ulcer	☐ N10. Prostate
☐ L11. Valley Fever	☐ M11. Ulcerative Colitis	☐ N11. Renal Failure
☐ L12. Other (_____)	☐ M12. Other (_____)	☐ N12. Other (_____)

Please answer the following questions for yourself and for anyone in your family applying for coverage:

1. ☐ **YES** ☐ **NO** Is anyone currently pregnant or an expectant parent?
   Due date: _____
   ☐ Yes ☐ No a. Has the pregnancy been confirmed by a physician or practitioner?
   ☐ Yes ☐ No b. Pregnancy complications?
   ☐ Yes ☐ No c. Multiple births expected?

2. ☐ **YES** ☐ **NO** Is anyone currently, or in the past five years has anyone been, a patient in a hospital, clinic, surgi-center, urgent care facility, or other medical facility as an inpatient or outpatient?

3. ☐ **YES** ☐ **NO** Does anyone currently use tobacco products, including cigarettes, pipes, cigars or chewing tobacco?

4. ☐ **YES** ☐ **NO** Does anyone currently have, or in the past 12 months has anyone had, any of the following?
   ☐ abnormal test or physical results ☐ pending test results
   ☐ health condition, illness or injury that may require treatment or surgery
   ☐ tests, treatment or surgery advised ☐ unexplained weight gain/loss or fatigue
   ☐ Worker's Compensation injury or illness ☐ condition not mentioned above in Section 2

Please use this table to explain any "YES" answers or items that you marked in Section 2. You may attach additional sheets.

Question Number	Name	Diagnosis/Treatment	Diagnosis Date	Treatment Status

Section 3: Family Medications

☐ **YES** ☐ **NO** Are you or anyone in your family applying for coverage currently taking any medications (including "over the counter" or "OTC" medicine) prescribed or recommended by a physician or practitioner?

If you answer "YES" to the question above, please use this table to explain. You may attach additional sheets.

Name	Medicine	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

PLEASE NOTE: If you leave out or misrepresent any information, the premium for your group coverage may change retroactive to the date the policy became effective. You or your authorized agent is entitled to receive a copy of this form.