

# 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 | Weight |
|---|--------------|---------------|--------------------|--------|--------|
|   | 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 <input type="checkbox"/> YES <input type="checkbox"/> NO   | D. Cancer/Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO  | H. Bones/Muscles/Joints <input type="checkbox"/> YES <input type="checkbox"/> NO  |
|---|--|---|
| <input type="checkbox"/> A1. Anemia<br><input type="checkbox"/> A2. Angina<br><input type="checkbox"/> A3. Angioplasty/Stent<br><input type="checkbox"/> A4. Aneurysm<br><input type="checkbox"/> A5. Blood Clots<br><input type="checkbox"/> A6. Blood Disorder<br><input type="checkbox"/> A7. Bypass<br><input type="checkbox"/> A8. Cardiac Arrhythmia<br><input type="checkbox"/> A9. Chest Pain<br><input type="checkbox"/> A10. Congestive Heart Failure<br><input type="checkbox"/> A11. Coronary Heart Disease<br><input type="checkbox"/> A12. Heart Murmur<br><input type="checkbox"/> A13. Hemophilia<br><input type="checkbox"/> A14. High/Low Blood Pressure<br><input type="checkbox"/> A15. High Cholesterol<br><input type="checkbox"/> A16. Pacemaker<br><input type="checkbox"/> A17. Palpitations<br><input type="checkbox"/> A18. Sickle Cell Anemia<br><input type="checkbox"/> A19. Stroke/TIA<br><input type="checkbox"/> A20. Varicose Veins<br><input type="checkbox"/> A21. Ventricular Tachycardia<br><input type="checkbox"/> A22. Other ( _____ ) | <input type="checkbox"/> D1. Brain<br><input type="checkbox"/> D2. Breast<br><input type="checkbox"/> D3. Colon<br><input type="checkbox"/> D4. Cyst<br><input type="checkbox"/> D5. Hodgkin's Disease<br><input type="checkbox"/> D6. Leukemia<br><input type="checkbox"/> D7. Liver<br><input type="checkbox"/> D8. Lung<br><input type="checkbox"/> D9. Lymphoma<br><input type="checkbox"/> D10. Melanoma<br><input type="checkbox"/> D11. Ovarian<br><input type="checkbox"/> D12. Pituitary<br><input type="checkbox"/> D13. Prostate<br><input type="checkbox"/> D14. Stomach<br><input type="checkbox"/> D15. Testicular<br><input type="checkbox"/> D16. Thyroid<br><input type="checkbox"/> D17. Other ( _____ )<br><input type="checkbox"/> D18. Stage of Cancer if known _____ | <input type="checkbox"/> H1. Bulging/Herniated Disk<br><input type="checkbox"/> H2. Carpal Tunnel Syndrome<br><input type="checkbox"/> H3. Fibromyalgia/CFS<br><input type="checkbox"/> H4. Fractures (Open or Closed)<br><input type="checkbox"/> H5. Gout<br><input type="checkbox"/> H6. Joint Replacement (Type: _____)<br><input type="checkbox"/> H7. Knee<br><input type="checkbox"/> H8. Muscular Dystrophy<br><input type="checkbox"/> H9. Neck/Back<br><input type="checkbox"/> H10. Shoulder<br><input type="checkbox"/> H11. Spina Bifida<br><input type="checkbox"/> H12. Sprain/Strain<br><input type="checkbox"/> H13. Other ( _____ ) |
| <b>B. Eyes/Ears/Nose/Throat <input type="checkbox"/> YES <input type="checkbox"/> NO</b><br><input type="checkbox"/> B1. Acoustic Neuroma<br><input type="checkbox"/> B2. Cataracts<br><input type="checkbox"/> B3. Chronic Sinusitis<br><input type="checkbox"/> B4. Cleft Lip/Palate<br><input type="checkbox"/> B5. Detached Retina<br><input type="checkbox"/> B6. Deviated Septum<br><input type="checkbox"/> B7. Ear Infections<br><input type="checkbox"/> B8. Glaucoma<br><input type="checkbox"/> B9. Retinopathy<br><input type="checkbox"/> B10. Other ( _____ )   | <b>E. Neurological <input type="checkbox"/> YES <input type="checkbox"/> NO</b><br><input type="checkbox"/> E1. Alzheimer's Disease<br><input type="checkbox"/> E2. Cerebral Palsy<br><input type="checkbox"/> E3. Epilepsy<br><input type="checkbox"/> E4. Head Injury<br><input type="checkbox"/> E5. Migraines<br><input type="checkbox"/> E6. Multiple Sclerosis<br><input type="checkbox"/> E7. Neuritis<br><input type="checkbox"/> E8. Paralysis/Hemiplegia<br><input type="checkbox"/> E9. Parkinson's Disease<br><input type="checkbox"/> E10. Seizures/Convulsions<br><input type="checkbox"/> E11. Other ( _____ )  | <b>I. Psychological <input type="checkbox"/> YES <input type="checkbox"/> NO</b><br><input type="checkbox"/> I1. ADD/ADHD<br><input type="checkbox"/> I2. Alcoholism<br><input type="checkbox"/> I3. Anxiety<br><input type="checkbox"/> I4. Autism<br><input type="checkbox"/> I5. Bipolar<br><input type="checkbox"/> I6. Depression<br><input type="checkbox"/> I7. Drug Abuse<br><input type="checkbox"/> I8. Eating Disorder<br><input type="checkbox"/> I9. Schizophrenia<br><input type="checkbox"/> I10. Suicide Attempt<br><input type="checkbox"/> I11. Other ( _____ )   |
| <b>C. Immune <input type="checkbox"/> YES <input type="checkbox"/> NO</b><br><input type="checkbox"/> C1. ALS<br><input type="checkbox"/> C2. AIDS<br><input type="checkbox"/> C3. HIV+<br><input type="checkbox"/> C4. Immuno Deficiency<br><input type="checkbox"/> C5. Lupus<br><input type="checkbox"/> C6. Psoriasis<br><input type="checkbox"/> C7. Scleroderma<br><input type="checkbox"/> C8. Other ( _____ )   | <b>F. Transplants <input type="checkbox"/> YES <input type="checkbox"/> NO</b><br><input type="checkbox"/> F1. Pending<br><input type="checkbox"/> F2. On Waiting List<br><input type="checkbox"/> F3. Completed Transplant<br><input type="checkbox"/> F4. Bone Marrow<br><input type="checkbox"/> F5. Stem Cell<br><input type="checkbox"/> F6. Organ (Type: _____ )   | <b>J. Diabetes/Endocrine <input type="checkbox"/> YES <input type="checkbox"/> NO</b><br><input type="checkbox"/> J1. Diabetes controlled by:<br><input type="checkbox"/> a. Diet<br><input type="checkbox"/> b. Oral Medication<br><input type="checkbox"/> c. Insulin<br><input type="checkbox"/> d. Other ( _____ )<br><input type="checkbox"/> J2. Adrenal Glands<br><input type="checkbox"/> J3. Growth Hormones<br><input type="checkbox"/> J4. Hyperthyroidism/Hypothyroidism<br><input type="checkbox"/> J5. Other ( _____ )  |
|   | <b>G. Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO</b><br><input type="checkbox"/> G1. Arthritis<br><input type="checkbox"/> G2. Osteoarthritis<br><input type="checkbox"/> G3. Rheumatoid Arthritis<br><input type="checkbox"/> G4. Other ( _____ )   | <b>K. Reproductive <input type="checkbox"/> YES <input type="checkbox"/> NO</b><br><input type="checkbox"/> K1. Breast Disorder<br><input type="checkbox"/> K2. Endometriosis<br><input type="checkbox"/> K3. Fibroids<br><input type="checkbox"/> K4. Menstrual Disorder<br><input type="checkbox"/> K5. Ovarian Cysts<br><input type="checkbox"/> K6. Other ( _____ )   |

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

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

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

Employee Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_