

Family Medical History Questionnaire



Section 1: About You and Your Job

Employee Name _____ Company Name _____ Original Date of Hire _____
 Daytime Phone# _____ Employment Status: Active Part-time Full-time Cobra

Section 2: About You and Your Dependents To Be Covered

Date of Birth	Gender	Height	Weight	Used Tobacco in Last 5 years
Employee ____/____/____	Male/Female	____Ft ____In	____lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse ____/____/____	Male/Female	____Ft ____In	____lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent1 ____/____/____	Male/Female	Full-time student?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent2 ____/____/____	Male/Female	Full-time student?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent3 ____/____/____	Male/Female	Full-time student?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent4 ____/____/____	Male/Female	Full-time student?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 3 Medical Conditions

Check all medical conditions that apply to any individual to be covered in Section 2. For all checked conditions, please fill out additional information in Section 5.

A. Cancer/Tumors	B. Heart/Circulatory	C. Mental Health / Neurological
<input type="checkbox"/> A1. Chemotherapy <input type="checkbox"/> A2. Hodgkin's Disease <input type="checkbox"/> A3. Leukemia <input type="checkbox"/> A4. Lymphoma <input type="checkbox"/> A5. Radiation Therapy <input type="checkbox"/> A6. Tumor/Mole/Cyst* <input type="checkbox"/> A7. Melanoma <input type="checkbox"/> A8. Other (_____)	<input type="checkbox"/> B1. Anemia* <input type="checkbox"/> B2. Aneurysm <input type="checkbox"/> B3. Congestive Heart Failure <input type="checkbox"/> B4. Coronary Artery Disease <input type="checkbox"/> B5. Hemophilia <input type="checkbox"/> B6. Hepatitis <input type="checkbox"/> B7. High Blood Pressure <input type="checkbox"/> B8. High Cholesterol* <input type="checkbox"/> B9. HIV/AIDS <input type="checkbox"/> B10. Irregular Heartbeat <input type="checkbox"/> B11. Stroke/TIA <input type="checkbox"/> B12. Other (_____)	<input type="checkbox"/> C1. ADD/hyperactivity* <input type="checkbox"/> C2. Alzheimer's <input type="checkbox"/> C3. Cerebral Palsy <input type="checkbox"/> C4. Cystic Fibrosis <input type="checkbox"/> C5. Depression <input type="checkbox"/> C6. Drug/Alcohol Abuse* <input type="checkbox"/> C7. Epilepsy/Seizure* <input type="checkbox"/> C8. Mental Retardation <input type="checkbox"/> C9. Multiple Sclerosis <input type="checkbox"/> C10. Paralysis/Hemiplegia <input type="checkbox"/> C11. Parkinson's <input type="checkbox"/> C12. Therapy* <input type="checkbox"/> C13. Other (_____)
D. Muscular/Skeletal	E. Lung/Respiratory	F. Intestinal/Endocrine
<input type="checkbox"/> D1. Arthritis* <input type="checkbox"/> D2. Bone/Fracture/Disk <input type="checkbox"/> D3. Lupus <input type="checkbox"/> D4. Muscular Dystrophy <input type="checkbox"/> D5. Neck/Back <input type="checkbox"/> D6. Spinal Column <input type="checkbox"/> D7. Other (_____)	<input type="checkbox"/> E1. Asthma/Allergy* <input type="checkbox"/> E2. Bronchitis/Pneumonia <input type="checkbox"/> E3. Emphysema <input type="checkbox"/> E4. Sleep Apnea <input type="checkbox"/> E5. Tuberculosis <input type="checkbox"/> E6. Other (_____)	<input type="checkbox"/> F1. Crohn's Disease <input type="checkbox"/> F2. Colon Disorder <input type="checkbox"/> F3. Diabetes* <input type="checkbox"/> F4. Gallbladder <input type="checkbox"/> F5. Hernia/Reflux/Ulcer <input type="checkbox"/> F6. IBS/Colitis* <input type="checkbox"/> F7. Pancreatitis <input type="checkbox"/> F8. Other (_____)
G. Glandular/Hormonal	H. Miscellaneous	J. Liver/Kidney
<input type="checkbox"/> G1. Adrenal Gland <input type="checkbox"/> G2. Pituitary <input type="checkbox"/> G3. Other (_____)	<input type="checkbox"/> H1. Birth Defects <input type="checkbox"/> H2. Burns <input type="checkbox"/> H3. Endometriosis* <input type="checkbox"/> H4. Gaucher's Disease <input type="checkbox"/> H5. Lou Gerhig's Disease <input type="checkbox"/> H6. Infertility Treatment <input type="checkbox"/> H7. Organ Transplant <input type="checkbox"/> H8. Polio <input type="checkbox"/> H9. Other (_____)	<input type="checkbox"/> J1. Kidney Stones <input type="checkbox"/> J2. Bladder or Kidney* <input type="checkbox"/> J3. Cirrhosis <input type="checkbox"/> J4. Neurogenic Bladder <input type="checkbox"/> J5. Polycystic Kidney <input type="checkbox"/> J6. Prostate Disorder <input type="checkbox"/> J7. Renal Failure <input type="checkbox"/> J8. Other (_____)
I. Eyes, Ears, Nose, Throat		
<input type="checkbox"/> I1. Chronic Ear Infections <input type="checkbox"/> I2. Cleft lip/palate <input type="checkbox"/> I3. Chronic Sinusitis <input type="checkbox"/> I4. Acoustic Neuroma <input type="checkbox"/> I5. Glaucoma <input type="checkbox"/> I6. Cataracts <input type="checkbox"/> I7. Retinopathy <input type="checkbox"/> I8. Other (_____)		

* If Checked, Supplemental Form Will Be Provided for Enrollee to Fill

Section 4: Medical Questions

Please answer these questions for all individuals listed in Section 2. For any YES responses, please complete Section 5.

- | | |
|---|--|
| K1. Is any individual to be covered currently pregnant or an expectant parent?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| K2. Has any individual to be covered received worker's compensation or disability income in the last 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| K3. Has any individual to be covered gained or lost over 20lbs in the last 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| K4. Has anyone been advised to have medical tests/treatments in the next 3 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| K5. Has any individual to be covered incurred medical claims over \$5,000 in the last 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| K6. Do you consider every individual to be covered to be in good health? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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