

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
ABNORMAL PAP SMEAR

Applicant Name \_\_\_\_\_

Group Name \_\_\_\_\_

1. List date(s), diagnosis and class of abnormal pap smear(s). Please contact the doctor's office if you do not know, and list his/her/their complete name(s) and address.

1) Date \_\_\_\_\_ Result \_\_\_\_\_      3) Date \_\_\_\_\_ Result \_\_\_\_\_  
2) Date \_\_\_\_\_ Result \_\_\_\_\_      4) date \_\_\_\_\_ Result \_\_\_\_\_  
Dr's Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Indicate treatment prescribed; include date(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Was surgery performed? YES  NO  If yes, indicated type of surgery, date(s), and include complete name and address of doctor who performed the surgery \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Have you had 3 **normal (Class I)** pap smears, at least 3 months apart since the last abnormal pap smear?  
YES  NO  If yes, give dates and results to include inflammatory changes.  
Date \_\_\_\_\_ Result \_\_\_\_\_  
Date \_\_\_\_\_ Result \_\_\_\_\_  
Date \_\_\_\_\_ Result \_\_\_\_\_

5. Have you ever been advised that you have: condyloma, genital warts or genital herpes?  
YES  NO

6. Have you contemplated, been advised to have, or planned to have any future treatment?  
YES  NO

7. Have you ever had an infertility problem? YES  NO  If yes, please provide details.  
\_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
ALCOHOL AND/OR DRUG TREATMENT

Applicant Name \_\_\_\_\_

Group Name \_\_\_\_\_

1. (A) Was treatment for alcohol and/or drug abuse?  
(B) If drug abuse, please indicate the type of drugs used. \_\_\_\_\_  
(C) Date treatment began: \_\_\_\_\_
2. Were you hospitalized? YES  NO   
If so, please provide details of confinement: \_\_\_\_\_  
\_\_\_\_\_
3. If drug use, have you ever had an HIV test? YES  NO   
If yes, what was the result: \_\_\_\_\_
4. Have you ever had a toxicology screen? YES  NO   
If yes, please provide date(s) and results: \_\_\_\_\_
5. Was this the first time you were treated? YES  NO   
If no, please provide details: \_\_\_\_\_  
\_\_\_\_\_
6. Was this treatment voluntary or due to medical, legal, family problems, or required by your employer?  
Please explain: \_\_\_\_\_  
\_\_\_\_\_
7. Has there been any alcohol or drug use since? YES  NO   
If yes, please provide details: \_\_\_\_\_
8. What was the total number of years spent drinking or using drugs? \_\_\_\_\_
9. Have there been any liver or other medical problems associated with alcohol or drugs? \_\_\_\_\_  
\_\_\_\_\_ If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
10. Are you currently active in a support group? YES  NO   
If yes, indicate length of time: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
ALLERGY AND/OR ASTHMA

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. What is the specific diagnosis? \_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_
3. Severity? Check appropriate box below and indicate frequency of symptoms.  
 Mild – no work time lost, less than 6 attacks per year, lungs clear between attacks, treated by desensitization shots or short-term bronchodilators.  
 Moderate – 6 to 12 attacks per year, slight wheezing or musical rales between attacks, continuous treatment by desensitization shots or bronchodilators. Steroid treatment limited to acute episode only.  
 Severe – more than 12 attacks per year, prolonged or continuous use of steroids, significant lung findings (constant wheezing or crackling rales).
4. Are symptoms seasonal? YES  NO
5. How often do you consult a doctor in a 12-month period for this condition? \_\_\_\_\_
6. Do you, or have you ever required allergy shots? YES  NO   
If yes, indicate frequency and duration: \_\_\_\_\_
7. List all medications other than allergy shots: \_\_\_\_\_
8. Have there ever been any episodes of asthma, difficulty breathing, shortness of breath or wheezing? YES  NO   
How often do you experience these symptoms? \_\_\_\_\_  
How long do the symptoms last? \_\_\_\_\_  
How quickly does the medication take effect? \_\_\_\_\_  
When did this last occur? \_\_\_\_\_
9. Has there ever been any diagnosis or a suspicion of emphysema, chronic bronchitis, bronchiectasis or chronic obstructive pulmonary disease (COPD)? YES  NO
10. Has there ever been any hospitalization or visits to the Emergency Room? YES  NO   
If yes, please provide dates, details and length of stay: \_\_\_\_\_  
\_\_\_\_\_
11. Has any time been lost from work or school due to allergies or asthma? YES  NO
12. Has any other treatment or testing been recommended, planned or contemplated? \_\_\_\_\_  
If yes, please provide details:

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
ANEMIA

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Provide the exact diagnosis of anemia (if unknown, check with your doctor): \_\_\_\_\_  
\_\_\_\_\_

2. Date of diagnosis? \_\_\_\_\_

3. Treatment? \_\_\_\_\_

4. Male or female (circle one)

5. Hemoglobin: \_\_\_\_\_ Red Blood Count: \_\_\_\_\_ Hematocrit: \_\_\_\_\_

6. Any suspicion of malignancy? YES  NO  If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_

7. Any surgery? YES  NO

8. Any bone marrow transplant? YES  NO

9. Are you still being treated? YES  NO  If yes, is this a recurrence? YES  NO

10. When was the last relapse? \_\_\_\_\_

11. Provide the dates of treatment, type of treatment for each event, and are you under doctor's care?  
\_\_\_\_\_ YES  NO   
\_\_\_\_\_ YES  NO   
\_\_\_\_\_ YES  NO

12. Please list doctor's name, address, and phone number:  
\_\_\_\_\_  
\_\_\_\_\_

**SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
ARTHRITIS**

**Applicant Name:** \_\_\_\_\_ **Group Name:** \_\_\_\_\_

1. Indicate type of arthritis. Contact your physician if you do not know.  
 Osteoarthritis                       Gouty Arthritis                       Other  
 Degenerative Arthritis               Psoratic Arthritis  
 Rheumatoid Arthritis                   Ankylosing Spondylitis
  
2. What medication(s) is being taken for arthritis? \_\_\_\_\_
  
3. When was this diagnosed? \_\_\_\_\_
  
4. Have any of the following medication(s) ever been prescribed?                      YES  NO   
If yes, please check the correct box and provide date and details:  
 Gold Shots               Methotrexate               Experimental Drugs               Steroids  
  
\_\_\_\_\_  
  
\_\_\_\_\_
  
5. Location of joints affected? \_\_\_\_\_
  
6. How often do symptoms occur and how long do they last? \_\_\_\_\_
  
7. Has this condition caused any limitations or deformity?                      YES  NO   
If yes, please provide details: \_\_\_\_\_  
  
\_\_\_\_\_
  
8. Has this condition required any hospitalization or surgery?                      YES  NO   
If yes, please provide dates and details: \_\_\_\_\_  
  
\_\_\_\_\_
  
9. Has there ever been time lost from work or school due to arthritis?                      YES  NO   
If yes, please provide dates and details: \_\_\_\_\_  
  
\_\_\_\_\_
  
10. Has any other treatment or testing been recommended, planned or contemplated? \_\_\_\_\_  
If yes, please provide details: \_\_\_\_\_



SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
ATTENTION DEFICIT DISORDER OR HYPERACTIVITY DISORDER

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Specific diagnosis(es) \_\_\_\_\_
2. What medication(s) is being taken? \_\_\_\_\_
3. Date began taking medication? \_\_\_\_\_
4. Is the medication being taken during school only or year round? \_\_\_\_\_
5. Is the medication controlling the disorder? \_\_\_\_\_
6. Has there ever been any counseling related to this disorder? YES  NO   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Has any other treatment been recommended, planned or contemplated? YES  NO   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
BLADDER OR KIDNEY DISORDER

Applicant Name \_\_\_\_\_

Group Name \_\_\_\_\_

1. Indicate exact diagnosis. Please call your physician's office if you do not know.  
 Simple Bladder Infection       Urethritis       Cystitis       Other  
 Pyelonephritis       Glomerulonephritis       Nephritis      \_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_
3. Has there been any previous history of kidney or bladder disorder? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
4. What tests were done to diagnose this condition? Dates? \_\_\_\_\_ Results? \_\_\_\_\_  
\_\_\_\_\_
5. Type of treatment:  
 Medication – names and dates taken: \_\_\_\_\_  
 Hospitalization – dates and duration of stay: \_\_\_\_\_  
 Surgery – dates, specific type of surgery and results: \_\_\_\_\_  
 Other – please provide details: \_\_\_\_\_
6. Was there any damage done to the kidney or bladder from this disorder? YES  NO   
If yes, please give details: \_\_\_\_\_
7. Do you have normal kidney and bladder functions? YES  NO   
If not, please provide details: \_\_\_\_\_
8. Any residuals or current problems? YES  NO   
If yes, please provide details: \_\_\_\_\_
9. Has any other treatment or testing been recommended, planned or contemplated?  
YES  NO  If yes, please provide details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
BLOOD PRESSURE

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Have you ever had any of the following? YES  NO   
If yes, please check the correct box(es) and provide details below.
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Congenital Heart Defects         | <input type="checkbox"/> Arteriosclerotic Heart Disease            | <input type="checkbox"/> Kidney Disorder                  |
| <input type="checkbox"/> Chest Pains                      | <input type="checkbox"/> Coronary Artery Disease                   | <input type="checkbox"/> Heart Murmur                     |
| <input type="checkbox"/> Heart Arrhythmia                 | <input type="checkbox"/> Cardiovascular Disease                    | <input type="checkbox"/> Poor Circulation                 |
| <input type="checkbox"/> Angina                           | <input type="checkbox"/> Enlarged Heart                            | <input type="checkbox"/> Hematuria                        |
| <input type="checkbox"/> Abnormal Stress Test             | <input type="checkbox"/> Stroke (TIA)                              | <input type="checkbox"/> Heart Attack                     |
| <input type="checkbox"/> Abnormal Electrocardiogram (EKG) | <input type="checkbox"/> Elevated Cholesterol and/or Triglycerides | <input type="checkbox"/> Blockage of the Carotid Arteries |
| <input type="checkbox"/> Heart Catheterization            | <input type="checkbox"/> Albumin in Urine                          |   |

Details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. When was hypertension (elevated blood pressure) first diagnosed? \_\_\_\_\_  
Reading: \_\_\_\_\_

3. Name of medication(s) and dosage(s) taken: \_\_\_\_\_  
If not being treated with medication, please explain: \_\_\_\_\_  
\_\_\_\_\_

4. Provide 3 blood pressure readings over the last 12 months, each must be taken at least 1 week apart. If you do not know, please call your doctor.  
**ONE READING MUST BE WITHIN THE LAST 6 MONTHS**  
Reading: \_\_\_\_\_ Date: \_\_\_\_\_  
Reading: \_\_\_\_\_ Date: \_\_\_\_\_  
Reading: \_\_\_\_\_ Date: \_\_\_\_\_

5. In the last 12 months, what was the highest reading? \_\_\_\_\_ Date: \_\_\_\_\_

6. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date Taken: \_\_\_\_\_

7. Has it ever been recommended that you be, or have you ever been, hospitalized to stabilize your blood pressure? YES  NO   
If yes, please provide full details: \_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
CANCER

Applicant Name \_\_\_\_\_

Group Name \_\_\_\_\_

1. Type of cancer (exact diagnosis): \_\_\_\_\_
2. Date diagnosed: \_\_\_\_\_
3. Was there surgery? YES  NO  Date of surgery: \_\_\_\_\_
4. Please provide the type of surgery: \_\_\_\_\_
5. Was there radiation? YES  NO  Dates: From: \_\_\_\_\_ To: \_\_\_\_\_
6. Was there chemotherapy? YES  NO  Dates: From: \_\_\_\_\_ To: \_\_\_\_\_
7. Date you were released: \_\_\_\_\_
8. Has there been any recurrence? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
9. Has there been complications from treatment? YES  NO   
If yes, please provide details, date(s), and what else was affected: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
CHOLESTEROL

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Date elevated cholesterol first diagnosed? \_\_\_\_\_  
Cholesterol reading at diagnosis: \_\_\_\_\_
  
2. List medication(s) and dosage(s) taken: \_\_\_\_\_
  
3. Please provide most recent blood lipid levels:  
Total Cholesterol                      Date \_\_\_\_\_                      Result \_\_\_\_\_  
HDL Cholesterol                      Date \_\_\_\_\_                      Result \_\_\_\_\_  
Triglycerides                      Date \_\_\_\_\_                      Result \_\_\_\_\_  
Height \_\_\_\_\_                      Weight \_\_\_\_\_                      Date \_\_\_\_\_
  
4. Has there ever been a diagnosis of, or a suspicion of, coronary artery disease?  
YES  NO  Please call the doctor's office to confirm. If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
  
5. Do you have a family history of heart disease? YES  NO   
If yes, provide relationship of family member with this history: \_\_\_\_\_
  
6. Has your doctor ever checked your liver functions due to the medication you take?  
YES  NO   
If yes, please give date(s) and results:

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
COLITIS, IRRITABLE BOWEL SYNDROME OR SPASTIC COLON

Applicant Name \_\_\_\_\_

Group Name \_\_\_\_\_

1. What is the specific diagnosis? Contact your physician's office if you do not know. \_\_\_\_\_  
\_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_
3. Has Ulcerative Colitis, Crohn's Disease, Regional Enteritis or Ileitis ever been mentioned as part of the diagnosis? YES  NO   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
4. Frequency of symptoms? \_\_\_\_\_
5. How long do the symptoms last? \_\_\_\_\_
6. When was the last time any symptoms occurred? \_\_\_\_\_
7. Type of treatment:  
Medication – names, dosages and dates taken: \_\_\_\_\_  
Hospitalization – dates and duration of stay: \_\_\_\_\_  
Tests – dates, specific type of test and results: \_\_\_\_\_  
Surgery – dates, specific type of surgery and residuals: \_\_\_\_\_
8. Current height and weight: \_\_\_\_\_  
Has there been any weight change in the past 12 months? YES  NO  If yes, please provide  
reason for change and pounds gained or lost: \_\_\_\_\_
9. What is the current status of your condition? \_\_\_\_\_
10. Has any other treatment or testing been recommended, planned, or contemplated?  
YES  NO   
If yes, please provide details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
DIABETES

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Taken \_\_\_\_\_
2. How was diabetes discovered? \_\_\_\_\_
3. Date diabetes diagnosed? \_\_\_\_\_
4. Fasting Blood Sugar at time of diagnosis: \_\_\_\_\_
5. How often do you consult your physician for examination and advice? \_\_\_\_\_  
Are you complaint? YES  NO  How often do you test your urine for sugar? \_\_\_\_\_  
\_\_\_\_\_ How often is sugar present? \_\_\_\_\_
6. Date and result of last doctor's visit: \_\_\_\_\_
7. How is your diabetes controlled? \_\_\_\_\_  
Name(s), strength(s), and dosage(s) of all medications prescribed: \_\_\_\_\_  
\_\_\_\_\_
8. Have you ever had: Elevated Blood Pressure, Heart Trouble, Eye Trouble, Kidney Trouble, Recurrent  
Infections, Non-Healing Sores or Ulcers? YES  NO  If yes, give details \_\_\_\_\_  
\_\_\_\_\_
9. Please advise most recent blood lipid levels: Total Cholesterol \_\_\_\_\_ HDL \_\_\_\_\_  
Triglycerides \_\_\_\_\_ Date Taken \_\_\_\_\_
10. Please give date and results of the last three Fasting Blood Sugar Readings (1 within last month, 2 within  
last year). Please contact your physician if you do not know:  
Date \_\_\_\_\_ Results \_\_\_\_\_, Date \_\_\_\_\_ Results \_\_\_\_\_, Date \_\_\_\_\_ Result \_\_\_\_\_  
Include your most recent hemoglobin A1C level: Date \_\_\_\_\_ Result \_\_\_\_\_
11. Have you ever been in a diabetic coma or had acidosis severe enough to require hospitalization? YES  
 NO  If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
12. Hospitalized to stabilize your diabetes? YES  NO  If yes, need date(s)

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
Dilatation & Curettage

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. What symptoms prompted this procedure? \_\_\_\_\_
2. When was the D & C performed? \_\_\_\_\_
3. Has there been a repeat? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
4. Has there been any recurrence of symptoms since D & C? YES  NO   
If yes, please provide full details: \_\_\_\_\_
5. Is there any further treatment planned or contemplated? YES  NO   
If yes, please provide full date(s) and details: \_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
DISABILITY

Applicant Name \_\_\_\_\_

Group Name \_\_\_\_\_

- |    |                                  |       |                  |
|----|----------------------------------|-------|------------------|
| 1. | Name of employees on disability: | Age:  | Reason Disabled: |
|    | _____                            | _____ | _____            |
|    | _____                            | _____ | _____            |
|    | _____                            | _____ | _____            |
|    | _____                            | _____ | _____            |

2. Provide the date when disabled and the date returned to work:
- |       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

3. Are any of these due to Workman's Comp claim? YES  NO

4. Are any of the above on Medicare due to disability? YES  NO   
If yes, please list those employees and when they were on Medicare:

_____	_____
_____	_____
_____	_____
_____	_____

5. Are any of the employees on COBRA or continuation due to disability? YES  NO   
If yes, please list the name:

\_\_\_\_\_

\_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
EAR INFECTIONS

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. How many ear infections has he/she had in the past 12 months? \_\_\_\_\_
2. Have the ear infections been associated with any other condition? YES  NO   
If yes, please provide details: \_\_\_\_\_
3. Did treatment ever last more than two weeks? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
4. Has this condition ever required surgery or tubes? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
5. Have there been any ear infections since the surgery or tubes? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
6. Has any other treatment been recommended, planned or contemplated? YES  NO   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Is hearing normal? YES  NO   
If no, please provide details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
ENDOMETRIOSIS

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. When was this condition diagnosed? \_\_\_\_\_
2. What type(s) of treatment or surgical procedures have been performed? \_\_\_\_\_  
\_\_\_\_\_
3. Date of surgery? \_\_\_\_\_
4. Has any other type of treatment or medication been given? YES  NO   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
5. Describe the symptoms you have had since surgery or treatment? \_\_\_\_\_  
\_\_\_\_\_
6. What medications do you continue to take? \_\_\_\_\_
7. Has any further treatment, surgery, or medication been advised or discussed?  
YES  NO  If yes, please provide full details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
EPILEPSY OR SEIZURE

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. What is the specific type of seizure disorder? \_\_\_\_\_
2. When was this first diagnosed? \_\_\_\_\_  
Please describe the symptoms and frequency of seizure(s): \_\_\_\_\_  
\_\_\_\_\_  
Was this the result of an injury? YES  NO   
If yes, indicate nature of injury: \_\_\_\_\_  
\_\_\_\_\_  
If this is a child, was the seizure associated with a high fever? YES  NO
3. Have you ever had an EEG, MRI, Brain Scan or any other tests related to your seizure disorder? YES  NO   
If yes, what were the results? \_\_\_\_\_  
\_\_\_\_\_
4. Has there been any change in mental capacity or personality? YES  NO   
If yes, please provide details: \_\_\_\_\_
5. List all medication(s) taken, including dosage: \_\_\_\_\_  
\_\_\_\_\_  
Last date medication taken: \_\_\_\_\_
6. When was the date of the last seizure? \_\_\_\_\_
7. Has this condition ever required hospitalization? YES  NO   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
8. If an adult, do you have a current valid driver's license? YES  NO

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
GENERAL

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

2. Have you ever received, or been advised to receive, dietary counseling? \_\_\_\_\_ If yes, need full diagnosis and full details with dates of treatment:

\_\_\_\_\_

3. Have you ever been advised your blood pressure was high or elevated? \_\_\_\_\_ If yes, need dates and full details: \_\_\_\_\_

\_\_\_\_\_

4. Have you ever been advised you had a high or elevated sugar reading? \_\_\_\_\_ If yes, need dates and full details with sugar readings: \_\_\_\_\_

\_\_\_\_\_

5. When was your most recent physical exam? \_\_\_\_\_

What tests were done? \_\_\_\_\_

What were the results for each test run? \_\_\_\_\_

Was any advice, recommendations, or referrals to any other medical practitioner given? \_\_\_\_\_

If yes, provide complete details: \_\_\_\_\_

\_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
GOUT

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Height: \_\_\_\_\_ Weight: \_\_\_\_\_
2. Have you ever been advised your blood pressure is high or elevated? YES  NO   
If yes, please provide date(s) and reading(s) at that time: \_\_\_\_\_
3. What advice or recommendations were given? \_\_\_\_\_
4. Have you had your blood pressure retested since that date? YES  NO   
What were those readings? \_\_\_\_\_
5. When was your gout diagnosed? \_\_\_\_\_  
Medication(s) taken: \_\_\_\_\_
6. How often do you have attacks or flares from gout? \_\_\_\_\_
7. What joints are affected? \_\_\_\_\_
8. Have you had any episodes of kidney stones? YES  NO   
If yes, please provide date(s) and type(s) of treatment received: \_\_\_\_\_  
\_\_\_\_\_
9. Have you ever been advised to decrease or discontinue use of alcohol? YES  NO
10. What was your most recent uric acid level?

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
HEADACHE OR MIGRAINE

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Indicate exact diagnosis: \_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_
3. What medication is being taken for this condition? \_\_\_\_\_  
Dosage \_\_\_\_\_ Frequency \_\_\_\_\_
4. What is the frequency of the headaches and how long do they last? \_\_\_\_\_
5. Is there a known cause for the headaches? \_\_\_\_\_
6. Have tests been performed to rule out tumors, arteriovenous malformations, etc.?  
YES  NO   
If yes, provide date(s), type of test(s), and results: \_\_\_\_\_  
\_\_\_\_\_
7. Have there been any hospitalizations or Emergency Room visits for this condition?  
YES  NO   
If yes, provide date(s), type of test(s), and results: \_\_\_\_\_  
\_\_\_\_\_
8. Has any time been lost from work or school due to this condition? YES  NO   
If yes, please provide dates, duration and details: \_\_\_\_\_  
\_\_\_\_\_
9. Has any other treatment been recommended, planned or contemplated? YES  NO   
If yes, please provide details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
HIATAL HERNIA OR ULCER

Applicant Name \_\_\_\_\_

Group Name \_\_\_\_\_

1. Indicate exact diagnosis: \_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_
3. How often do you have symptoms? \_\_\_\_\_  
Indicate date you last exhibited symptoms: \_\_\_\_\_
4. Has there ever been any evidence of hemorrhage? YES  NO   
If yes, please provide details: \_\_\_\_\_
5. If ulcer history, was this caused by excessive alcohol intake? YES  NO   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
6. Medication – name(s) and dosage: \_\_\_\_\_  
Is medication still being taken? YES  NO   
If no, date it was discontinued: \_\_\_\_\_
7. Hospitalization? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
8. Surgery? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
9. Has there been any recurrence of symptoms since surgery? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
MENTAL-NERVOUS

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Type(s) of treatment? (Check all that apply)  
 Individual Psychotherapy       Marital Counseling       Hospitalization  
 Group Psychotherapy       Medication       Family Psychotherapy  
 Other, please explain: \_\_\_\_\_
2. A specific diagnosis: \_\_\_\_\_  
If situational depression/anxiety, please indicate cause: \_\_\_\_\_
3. Indicate date first treated: \_\_\_\_\_  
Frequency of treatment/visits: \_\_\_\_\_  
Date last treated: \_\_\_\_\_  
Was there any weight change? YES  NO  Gained: \_\_\_\_\_ Lost: \_\_\_\_\_
4. Names, strengths, and dosages of all medications prescribed: \_\_\_\_\_  
Still taking medication? YES  NO  If no, date discontinued: \_\_\_\_\_
5. If medication has been discontinued, was this at the advise of your doctor? YES  NO
6. Has there been any treatment in the past for this or a similar condition? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
7. Has there been any hospitalization for this or any similar condition? YES  NO   
If yes, please provide date(s) and length of stay for each hospitalization: \_\_\_\_\_  
\_\_\_\_\_
8. Has any time been lost from work or school for this or any similar condition?  
YES  NO  If yes, please provide date(s) and length of time \_\_\_\_\_
9. Has there ever been any suicide attempt(s) or thought(s)? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
10. Any history of alcohol and/or drug abuse? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
11. Has there ever been any electroshock therapy? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
MITRAL VALVE PROLAPSE

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Date Mitral Valve Prolapse was diagnosed? \_\_\_\_\_
2. Was this found on a routine physical examination? YES  NO   
If no, how was it diagnosed? \_\_\_\_\_  
Was an echocardiogram (ECHO) performed? YES  NO   
If yes, date(s) and results: \_\_\_\_\_
3. Have there ever been any symptoms (chest pain, palpitations, shortness of breath, etc.)?  
YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
4. Has medication ever been prescribed for this condition? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
5. If medication has been discontinued, was it discontinued by yourself or at the doctor's request? Please  
provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
6. Do you have a murmur? YES  NO   
If yes, indicate exact diagnosis of murmur: \_\_\_\_\_
7. Have there ever been any hospitalizations or Emergency Room visits for this condition(s)?  
YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
8. Has any other treatment been recommended, planned or contemplated? YES  NO   
If yes, please provide details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
MOLE, TUMOR, CYST

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. What was the specific diagnosis from the Pathology Report? \_\_\_\_\_  
\_\_\_\_\_
2. If polyps, please provide number of polyps found and diagnosis of each: \_\_\_\_\_  
\_\_\_\_\_
3. Where was the mole, tumor, polyp or cyst located? \_\_\_\_\_  
\_\_\_\_\_
4. Typed of treatment:  
 Surgery/Excision \_\_\_\_\_  
 Incision/Drainage \_\_\_\_\_  
 Biopsy \_\_\_\_\_  
 Medications \_\_\_\_\_
5. Has there been any recurrence? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
6. Date of last treatment or problems? \_\_\_\_\_
7. Are there any residuals or current symptoms? YES  NO   
If yes, please provide full details: \_\_\_\_\_
8. Is there any future treatment or surgery contemplated? YES  NO   
If yes, please provide full details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
PREGNANCY

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Who is currently pregnant? \_\_\_\_\_  
Relationship: \_\_\_\_\_
2. Current due date? \_\_\_\_\_
3. First pregnancy? YES  NO  Any complications? YES  NO
4. Is this to be a single or multiple birth? \_\_\_\_\_ If multiple, how many? \_\_\_\_\_
5. Has there been any previous miscarriage or premature labor? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
6. Have you ever been treated with infertility drugs or infertility work-ups? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_
7. Has there ever been any infertility including artificial insemination, embryo implants, or any other in-vitro procedures or complications thereof? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
PROSTATE

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Exact diagnosis: \_\_\_\_\_
2. Age: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_
3. PSA count at diagnosis: \_\_\_\_\_
4. What tests were done? \_\_\_\_\_
5. What type of treatment? \_\_\_\_\_
6. Has a biopsy been done or suggested? YES  NO  If yes, please provide the date(s) and results:  
\_\_\_\_\_
7. Any follow-up test or treatment? YES  NO  If yes, please provide date(s) and details: \_\_\_\_\_
8. Has there been any implants or any suggested? YES  NO  If yes, please provide date(s) and results: \_\_\_\_\_  
\_\_\_\_\_
9. Have there been any further complications? YES  NO  If yes, please provide full details: \_\_\_\_\_

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
STRAIN-SPRAIN-INJURY

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Indicate the exact diagnosis: \_\_\_\_\_
2. Date of onset of symptoms or injury: \_\_\_\_\_  
Was this work related? YES  NO   
If yes, please provide details: \_\_\_\_\_  
If work related, please provide documentation of Worker's Compensation liability.
3. Type of treatment (check those that apply and provide details with dates):  
 Hospitalization: \_\_\_\_\_  
 Physical Therapy: \_\_\_\_\_  
 Chiropractic: \_\_\_\_\_  
 Surgery: \_\_\_\_\_  
 Medication: \_\_\_\_\_  
 Other, please explain: \_\_\_\_\_
4. If pins, plates, or screws were inserted, are they permanent? YES  NO   
If temporary, please provide date of removal or anticipated removal: \_\_\_\_\_
5. If symptoms or injury pertain to the back or neck, was there any spinal cord involvement? YES  NO   
 If yes, please provide details, including specific vertebra/discs involved, treatment, and residual effects: \_\_\_\_\_
6. Has there been any recurrence of symptoms? YES  NO   
If yes, please provide details: \_\_\_\_\_
7. Has any time been lost from work or school due to this problem? YES  NO   
If yes, please provide details: \_\_\_\_\_
8. Date released from all treatment? \_\_\_\_\_ Is (was) there any litigation regarding this injury? YES  NO   
 If yes, please provide details: \_\_\_\_\_  
Please provide date litigation was completed and include outcome: \_\_\_\_\_  
\_\_\_\_\_
9. Is there any remaining disability (provide percentage) or limitations in activities?  
YES  NO  If yes, please provide details: \_\_\_\_\_
10. Has any other treatment or testing been recommended, planned or contemplated?  
YES  NO  If yes, please provide details:

SUPPLEMENT TO MEDICAL QUESTIONNAIRE/  
THYROID DISORDERS

Applicant Name \_\_\_\_\_ Group Name \_\_\_\_\_

1. Indicate exact diagnosis: \_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_
3. What medication(s) is being taken? \_\_\_\_\_
4. Has there ever been any surgery or radioactive iodine treatment? YES  NO   
If yes, please provide date(s) and details: \_\_\_\_\_  
\_\_\_\_\_
5. What is the current status of the thyroid after the surgery or radioactive iodine treatment?  
\_\_\_\_\_
6. Has there every been a goiter or nodule(s)? YES  NO   
Please provide details: \_\_\_\_\_
7. Has there ever been any of the following:  Tremors  Palpitations  High Blood Pressure? If  
yes, please check the correct box(es) and provide details: \_\_\_\_\_  
\_\_\_\_\_
8. Has this condition ever required any hospitalization? YES  NO   
If yes, please provide details: \_\_\_\_\_
9. What is the current status? \_\_\_\_\_
10. Has any other treatment been recommended, planned or contemplated? YES  NO   
If yes, please provide details: \_\_\_\_\_