

MercyOne Application Checklist

Please follow this checklist to ensure your application is complete and avoid unnecessary underwriting delays.

- Complete the General Member Information section (page 1). Include the name, gender, height, weight, social security number, and date of birth for every person applying for coverage.
- Request an effective date on (page 2). You may select either the 1st or 15th of the month.
- Obtain and send to Mercy Health Plans a copy of any Certificate of Creditable Coverage, if you have had prior health insurance coverage through another carrier. We will need a copy of this Certificate in order to grant you a waiver for any pre-existing conditions.
- Select the plan option for which you will be applying (page 2 or page 3)
- Answer all Health History questions (pages 4 and 5). Also, list all prescriptions and over-the-counter medications taken for each person applying for coverage. Failure to answer these questions will delay the underwriting of your application.
- Give us complete details in the attached *Secondary Health Questionnaire*, if you answered "yes" to any Health History conditions listed on page 5 (question # 8). The page number(s) listed next to the condition(s) in this section refer to corresponding questions in the *Secondary Health Questionnaire*.
- List the primary care physician, phone number, and date of last visit for each person applying for coverage (page 5).
- Sign and date the Authorization to Use and Disclose Protected Health Information (page 7). This applies to each enrolling Applicant age 18 or over. **If your application is dated more than 60 days before the requested effective date, you will be asked to re-apply.**
- Complete the Payment Information (page 8). Payment for this policy can be made by automatic withdrawal from a checking or savings account. Mercy Health Plans also accepts credit card payments through Visa, MasterCard or American Express. All payment options are withdrawn on a monthly basis on or about the 15th of the month.

If you need assistance in completing your application, please contact your agent. If you do not have an agent, please contact the MercyOne Sales Department at 314-214-8050 or 800-330-8293.



Individual Application for Comprehensive Health Insurance

Mercy Health Plans
 14528 S Outer 40, Ste. 300
 Chesterfield, MO 63017-5743
 314-214-8050 • 1-800-330-8293
 www.mercyhealthplans.com



Please complete in black only.

Application Type

Coverage Information (Select One): New Coverage _____ Effective Date Requested: ___/___/___

Change to current plan Member Number: _____ Effective Date of Change: ___/___/___

Add dependent (s) to current coverage Member Number: _____ Effective Date of Change: ___/___/___

Applicant Information

Please enter the following applicant information: (If applying for *Child Only Coverage*, record the child's information in the following section. Please submit a separate application for each Child Only Applicant.)

NAME: First Middle Last Subscriber's Occupation: _____

HOME ADDRESS: (Street & P.O. Box if applicable) City State Zip County

Home Phone: (_____) _____ Best time to call: Day Evening E-mail (this will not be shared with a 3rd party): _____

Work Phone: (_____) _____ Cell Phone #: (_____) _____

Are you a United States citizen? Yes No
 If "No", do you possess a Green Card (Permanent Resident Card) or a temporary U.S. visa? Yes No If "No", please explain: _____

Are you a legal resident of the state of Missouri? Yes No If "No", please explain: _____

Have you resided in the United States for the past six (6) consecutive months? Yes No

General Member Information

Please complete information below for all family members applying for coverage (attach other pages, if needed).

Name		Relationship to Applicant	Sex M/F	Height		Weight lbs.	SSN#	Date of Birth (mm/dd/yyyy)		
First	Last			Ft.	In.			mm	dd	yyyy
		Self								
		Spouse								
		Child								
		Child								
		Child								
		Child								
		Child								
		Child								

Producer Information

If you have a Producer (Broker or Agent) that will be assigned to your account, HAVE HIM/HER COMPLETE THIS SECTION.

Note: Mercy Health Plans (MHP) may share medical information with the Producer concerning you or your covered dependents that is contained in this application or discovered in the course of processing the application. The writing (and any assisting) Producer's current Missouri health insurance license must be on file with MHP prior to acceptance of this application.

Do you know of any significant medical information relating to the applicant or any of his/her dependents that has not been reported on this form? Yes No

For purposes of processing commission, please provide the following information*:

Agency Name: Lang Insurance Service

Broker's Name: Steven J. Lang

Broker's Telephone #: (636) 229-7000

Broker's Email: inbox@langinsurance.com

Broker's Signature: _____

Date: _____ / _____ / 2010

Notification: Broker Only (Broker to receive policy)
 Broker and Subscriber (Member to receive policy, Broker to receive copy by email)

* Please fill out this information as it appears on your W-9 form.

Coverage and Benefit Selection

To choose the type of coverage that you would like, select ONE option from EACH of the sections numbered 1, 2, 3 and 4 below.

1) TYPE OF COVERAGE: Applicant only (Ages 19-65 yrs.) Child Only (Age 6 mos -18 yrs) Applicant & spouse
 Applicant & unmarried children* Applicant, spouse & unmarried children*

* Unmarried dependent children up to age 25.

2) EFFECTIVE DATE REQUESTED: _____/_____/_____ (1st or 15th of the month)

Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.

3) OPTIONAL RIDERS: Family Services Rider (tubal ligations & vasectomies) – Additional \$4.50 /month per family. (Applies only to Applicant and enrolled spouse) Yes No

Prosthetic Services Rider (Mandated Offer) – Additional \$500.00 /month per Applicant Yes No
 Please note that if declined, the standard MHP prosthetic benefit with an annual limit of \$5,000 will apply.

4) PLAN SELECTION:

A. Traditional Plan Option: Choose ONLY ONE Plan option.

Note: Maternity benefits apply only to the applicant or applicant's spouse, and will not begin until after you have been covered for 12 months.

You must be over 19 years of age to elect maternity benefits.

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit PCP/Specialist	Coinsurance In-network/Out-of-Network	Prescription Copays (Tier 1/ Tier 2/ Tier 3/ Tier 4)
<input type="checkbox"/> A-10	12 month	No	\$1,000	\$2,000	\$20/\$40	100%/70%	\$10/\$40/\$65
<input type="checkbox"/> B-10	12 month	No	\$2,500	\$5,000	\$20/\$40	100%/70%	\$10/\$40/\$65
<input type="checkbox"/> AA-10	12 month	Yes	\$1,000	\$2,000	\$20/\$40	100%/70%	\$10/\$40/\$65
<input type="checkbox"/> BB-10	12 month	Yes	\$2,500	\$5,000	\$20/\$40	100%/70%	\$10/\$40/\$65
<input type="checkbox"/> D-10	12 month	No	\$500	\$1,000	\$20/\$40	80%/60%	\$10/\$40/\$65
<input type="checkbox"/> E-10	12 month	No	\$1,000	\$2,000	\$20/\$40	80%/60%	\$10/\$40/\$65
<input type="checkbox"/> F-10	12 month	No	\$2,500	\$5,000	\$20/\$40	80%/60%	\$10/\$40/\$65
<input type="checkbox"/> DD-10	12 month	Yes	\$500	\$1,000	\$20/\$40	80%/60%	\$10/\$40/\$65
<input type="checkbox"/> EE-10	12 month	Yes	\$1,000	\$2,000	\$20/\$40	80%/60%	\$10/\$40/\$65
<input type="checkbox"/> FF-10	12 month	Yes	\$2,500	\$5,000	\$20/\$40	80%/60%	\$10/\$40/\$65

B. HDHP/HSA Plan: Choose ONLY ONE Plan option.

Note: Maternity benefits apply only to the applicant or applicant's spouse, and will not begin until after you have been covered for 12 months.

You must be over 19 years of age to elect maternity benefits.

Plan	Term Length	Maternity	In- Network Deductible	Out-of- Network Deductible	Office Visit PCP/Specialist	Coinsurance In-network/Out-of-Network	Prescription Copays (Tier 1/ Tier 2/ Tier 3/ Tier 4)
<input type="checkbox"/> 1500B-10	12 month	No	\$1,500	\$3,000	80/60%	80%/60%	\$10/\$40/\$65
<input type="checkbox"/> 3000A-10	12 month	No	\$3,000	\$6,000	100/75%	100%/75%	100%
<input type="checkbox"/> 5000A -10	12 month	No	\$5,000	\$10,000	100/75%	100%/75%	100%
<input type="checkbox"/> 1500BB-10	12 month	Yes	\$1,500	\$3,000	80/60%	80%/60%	\$10/\$40/\$65
<input type="checkbox"/> 3000A-10	12 month	Yes	\$3,000	\$6,000	100/75%	100%/75%	100%
<input type="checkbox"/> 5000A-10	12 month	Yes	\$5,000	\$10,000	100/75%	100%/75%	100%

Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please forward my information to Mercy Health Plans' banking partner.

No, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please DO NOT forward my information to Mercy Health Plans' banking partner.

Other Health Coverage	Yes	No
Answer "Yes" or "No" and list and/or submit additional information as requested below.		
1) Are you or anyone that is applying for coverage currently eligible for Medicare? If "yes", please list name(s): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Note: Anyone who is eligible for Medicare is not eligible for coverage under this Policy.		
2) Have you ever had your coverage through Mercy Health Plans terminated for failure to pay premiums? If "yes", please list name(s): _____ If your coverage was terminated by Mercy Health Plans for non-payment of premiums, you must wait 12 months before applying for coverage and one month's advance premium may be required.	<input type="checkbox"/>	<input type="checkbox"/>
3) Did you and/or your spouse and/or your eligible dependents have creditable coverage from a health insurance carrier within the past 63 days? (Creditable Coverage is any health insurance except a short term policy) If "yes", you may be eligible for pre-existing credit. If applicable, submit a copy of the Certificate of Creditable Coverage for each person applying.	<input type="checkbox"/>	<input type="checkbox"/>
Lifestyle	Yes	No
Answer "Yes" or "No" to the questions below.		
1) Have you or any family member(s) who are applying for coverage smoked tobacco within the last 12 months? If "yes", please list name(s): _____ Note: Additional testing may be required to confirm this information.	<input type="checkbox"/>	<input type="checkbox"/>
2) Have you or any family member(s) who are applying for coverage used other smokeless tobacco products within the last 12 months? If "yes", list name(s): _____ Note: Additional testing may be required to confirm this information.	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you use alcohol or illicit drugs? If 'Yes', which do you drink/use? <input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit drugs <input type="checkbox"/> Both alcohol and drugs If 'Yes', how often do you drink/use? <input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you used alcohol or illicit drugs in the past? If 'Yes', when did you stop using them? ____/____(mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>

Health History

Answer "Yes" or "No" to the questions below.

Yes	No
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1) Is any proposed insured currently pregnant, an expectant parent, or in the process of adoption or surrogate pregnancy?

Note: You are not eligible for coverage if you are a male or female expectant parent

<input type="checkbox"/>	<input type="checkbox"/>
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2) Do you or any family member(s) who are applying for coverage have any pain, complaints or health conditions that a reasonably prudent person would anticipate requiring future medical treatment or surgery?

<input type="checkbox"/>	<input type="checkbox"/>
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If so, what are those health conditions, and what treatments are considered? (Attach other pages if needed)

3) In the last ten years have you or any family member(s) who are applying for coverage had any pain, complaints, symptoms, diagnoses or treatments of any disease, disorder or injury, or had any test results that you were told were abnormal or needed further evaluation?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If so, what are those conditions, disease states, injuries or abnormal test results? (Attach other pages if needed)

4) Are you or any family member(s) applying for coverage taking or have taken any drugs (including any over-the-counter drugs) or products during the past five (5) years?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If 'Yes', please list below:

- All prescription medication or over-the-counter drugs or products that are taken;
- All medication that you have been advised to take but have not;
- The person for whom each drug is prescribed;
- The prescribing physician, and
- The conditions that the drugs are prescribed to treat (attach other pages, if needed). It is important to note that if you are taking any prescribed medication, you should answer "Yes" to one or more of the questions relating to organ systems/diseases in question # (6) below.

Name of Drug	Currently on Rx? (Y/N)	Dosage Amt (e.g. 100 mg/daily)	Refill Frequency	Person Drug Prescribed For	Prescribing Physician	Condition Drug Prescribed to Treat

5) List Primary Care Physician, phone number and date of last visit for each person applying:

Name of Applicant:	Primary physician name, phone number, city & state:	Date of last visit:

	Yes	No
6) Has any person applying for coverage had, or are expecting to have, placement, replacement, treatment, surgery, or maintenance of an internal or external implant or prosthetic device?	<input type="checkbox"/>	<input type="checkbox"/>
7) Do you or any family member(s) applying for coverage currently have any health condition(s) or diseases pertaining to the organ systems or diseases listed below?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you or any family member(s) applying for coverage ever been diagnosed or treated (within the past 10 years) for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases listed below?	<input type="checkbox"/>	<input type="checkbox"/>

Check "Yes" or "No" for all conditions listed below as they apply for any covered family member.

NOTE: If you answer "Yes" to any of these screening questions, you must also answer the *Secondary Health Questionnaire* related to those conditions. The page numbers listed below refer to related questions in the attached *Secondary Health Questionnaire*.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes, (pg 9)	<input type="checkbox"/>	<input type="checkbox"/>	10. Nervous System/Brain Disorder/Headache/Epilepsy/Seizure Disorder, (pgs 12& 13)
<input type="checkbox"/>	<input type="checkbox"/>	2. Endocrine/Thyroid/Pituitary/Adrenal, (pg 9)	<input type="checkbox"/>	<input type="checkbox"/>	11. Mental or Psychiatric Condition/Depression/Behavioral (e.g., Attention-Deficit Hyperactivity Disorder)or Eating Disorder, (pg 13)
<input type="checkbox"/>	<input type="checkbox"/>	3. High Blood Pressure/Hypertension, (pg 9)	<input type="checkbox"/>	<input type="checkbox"/>	12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder, (pgs 13 & 14)
<input type="checkbox"/>	<input type="checkbox"/>	4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol, (pgs 9 & 10)	<input type="checkbox"/>	<input type="checkbox"/>	13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disorder, or TMJ, (pg 14)
<input type="checkbox"/>	<input type="checkbox"/>	5. Respiratory/Lung/Asthma/Allergies/TB/COPD, (pgs 10 & 11)	<input type="checkbox"/>	<input type="checkbox"/>	14. Muscular Disorder/Lupus/Connective Tissue Disorder/Auto-Immune Disorder, (pgs 14 & 15)
<input type="checkbox"/>	<input type="checkbox"/>	6. Ears/Eyes/Nose/Throat/Skin Disorder, (pg 11)	<input type="checkbox"/>	<input type="checkbox"/>	15. Cancers/Tumors/Cysts/Neoplasms, (pg 15)
<input type="checkbox"/>	<input type="checkbox"/>	7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/ Polyps/ Hepatitis/Cirrhosis (pgs 11& 12)	<input type="checkbox"/>	<input type="checkbox"/>	16. Have you or any family member(s) applying for coverage been positively diagnosed or treated for HIV/AIDS/ARC/Chronic or Infectious Disease, (pg 15)?
<input type="checkbox"/>	<input type="checkbox"/>	8. Prostate/Reproductive Organ Disorder/Infertility/STD, (pg 12)	<input type="checkbox"/>	<input type="checkbox"/>	17. Any Other Illness, Disease or Injury (pg 15)
<input type="checkbox"/>	<input type="checkbox"/>	9. Urinary Tract/Kidney or Renal Disease, (pg 12)			

Statements of Understanding

Please read all statements below.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans (MHP).
2. I understand that I will receive either an acceptance, premium adjustment, or denial from MHP or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application.
3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full. If my coverage is terminated, I will be unable to reapply for an Individual policy with Mercy Health Plans for one year.
4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.
5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical and/or mental health condition disclosed within this application will not be covered for up to 12 months after my effective date. (Credit may be given for prior creditable coverage upon receipt of certificate of creditable coverage.)
6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage may be rescinded in its entirety at MHP's discretion.
7. I understand that I or any of my covered family members may need to obtain a physical examination at my own expense and submit the results as part of my application for coverage, if such an examination has not been performed within the last two years.
8. I understand that I or any of my covered family members have an obligation to notify Mercy Health Plans if we become aware of any medical conditions/injuries/disease states that would cause a reasonably prudent person to seek or require medical attention, from the time this application is signed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change.
9. I understand that if I purchase maternity benefits, they apply only to my spouse or me and do not begin until we have been covered for 12 months under the plan that includes the maternity benefit. Maternity benefits are not available for our dependent children and do not apply to child only plans.
10. I understand and agree that Mercy Health Plans may obtain or request information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.
11. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.

Authorization to Use and Disclose Protected Health Information

NOTE: It is required that this *Authorization to Use and Disclose Protected Health Information* be completed and submitted with the application. The application is not complete without this authorization form.

Each person age 18 or over who is to be covered by this policy must sign at the bottom of this form.

I authorize Mercy Health Plans (MHP) or its affiliates to obtain necessary individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports from physicians, hospitals or other health care providers pertaining to my care or the care of any other dependent(s) listed on the application for insurance. I understand that this information can be used to determine my/our eligibility for insurance, and that those records can be requested as far back as the past ten years.

I authorize MHP to share necessary information with my Producer (Broker or Agent). I understand that Mercy Health Plans may disclose individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports to other entities in the course of its business operations or as required or permitted by law or as set out in the Mercy Health Plans Notice of Privacy Practices and authorize such disclosure. Federal regulations require that we inform you that under certain limited circumstances (e.g., judicial subpoena, state health department, etc.) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by such regulation.

This authorization is valid for the duration of my coverage with Mercy Health Plans. I understand that this authorization is voluntary and that I may revoke this authorization at any time; however, if I do so before I am enrolled in the policy(ies), my application for coverage may be denied. A revocation request must be sent to MHP in writing to our home address, or via e-mail. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

By signing, I agree that I have fully read this entire application, including all seven pages of the Secondary Health Questionnaire, and I understand and agree with all statements contained herein. I also certify that I have answered all questions on the application and Secondary Health Questionnaire completely and accurately. I understand and agree to the release of information for the purpose(s) described above in this document.

All listed applicants 18 years of age and older must agree to the terms of this authorization by signing below.

	Signature Required:	Printed Name:	Date:
Applicant	X		
Applicant's Spouse	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		

If your application is dated more than 60 days before the requested effective date for coverage, a new application may need to be completed.

Note: Coverage will not begin until all necessary information is received by MHP. MHP will notify you of the approved effective date.

Payment Information

All premium payments are made either via debit ACH (automatic withdrawal) or by Credit Card payment*.

Applicant's Name: _____

Please check your method of payment:

<input type="checkbox"/> Automatic Bank Account Withdrawal	
<input type="checkbox"/> Checking account (attach voided check below) Account # _____ Routing # _____ <input type="checkbox"/> My first payment only <input type="checkbox"/> My first and ongoing payments <input type="checkbox"/> My ongoing payments only (first payment made by other method)	
<input type="checkbox"/> Savings Account (attach deposit slip) Account # _____ Routing # _____ <input type="checkbox"/> My first payment only <input type="checkbox"/> My first and ongoing payments <input type="checkbox"/> My ongoing payments only (first payment made by other method)	
<p><i>I authorize Mercy Health Plans (MHP) to draft my Bank Account on the 15th of each month for the amount of my monthly premium. I understand that this authorization is in effect until I notify MHP in writing that I no longer desire these services, allowing them reasonable time to act upon my notification.</i></p>	
Signature of Account Holder: X	Date: X
<input type="checkbox"/> Credit Card Payment	
Type of Credit Card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	
Credit Card Number: _____	Expiration Date: ____/____(mm/yy)
Cardholder's Name (as it appears on the card): _____	
Cardholder's Address: _____	City State Zip
Telephone: _____	
<input type="checkbox"/> I authorize Mercy Health Plans to charge my credit card on the 15 th of each month for the amount of my monthly premium.	
<input type="checkbox"/> I authorize a one-time charge to my credit card for \$_____ premium.	
Signature of Cardholder: X	Date: X

* *Note: You may be charged an additional fee for insufficient funds or incorrect banking information*

Attach Voided Check Here

SECONDARY HEALTH QUESTIONNAIRE

Note: You must answer each question for yourself and for everyone you are applying for. Answer all categories 'YES' or 'NO'. If you answer 'YES' to a category, make sure to complete the detailed section not only for yourself but for everyone you are applying for.

Have you/family member ever been diagnosed with, or sought treatment for any of the following conditions?

	YES	NO
1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes/Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Diabetes/Pre-diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Which type of diabetes has been diagnosed?		
Type I, Insulin Dependent	<input type="checkbox"/>	<input type="checkbox"/>
If Type I, # units of insulin per day?		
<input type="checkbox"/> < 75 units <input type="checkbox"/> > 100 units		
<input type="checkbox"/> 75-100 units <input type="checkbox"/> Don't know		
Type II, Non-Insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
Gestational	<input type="checkbox"/>	<input type="checkbox"/>
Date of delivery (in MM/YYYY)	____/____/____	
Other type/Don't know	<input type="checkbox"/>	<input type="checkbox"/>
Date initial diabetes diagnosis made: (MM/YYYY)	____/____/____	
Oral meds to control blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>
Provide recent HbA1c or average glucose levels (within last six months).		
If fasting glucose levels		
<input type="checkbox"/> 65-115 <input type="checkbox"/> 116-175 <input type="checkbox"/> >175		
If random glucose levels		
<input type="checkbox"/> <200 <input type="checkbox"/> 201-250 <input type="checkbox"/> >250		
If HbA1c level _____		
In addition, do you/family member have any of these conditions?		
Diabetic eye complications	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems/Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
2. Endocrine System/Thyroid/Pituitary/Adrenal	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Hyperthyroidism/Hashimoto's Thyroiditis/Graves Disease/Excess thyroid hormone	<input type="checkbox"/>	<input type="checkbox"/>
What kind of treatments have you/family member had for this?		
<input type="checkbox"/> Surgery <input type="checkbox"/> Radioactive Iodine <input type="checkbox"/> Other		
If surgery, date of surgery: (MM/YYYY)	____/____/____	
If surgery not done, does RX control disease?	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism-low thyroid hormone	<input type="checkbox"/>	<input type="checkbox"/>
Toxic Thyroid Goiter-Plummer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
When was diagnosis made (in MM/YYYY)?	____/____/____	
Hyperparathyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Did you/family member have surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, does medication control disease?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Hyperaldosteronism (Cushing's disease)	<input type="checkbox"/>	<input type="checkbox"/>
Is the cause of disease known?	<input type="checkbox"/>	<input type="checkbox"/>
If cause is known, describe condition:		

	YES	NO
Date condition diagnosed: (in MM/YYYY)	____/____/____	
Is the condition stable with treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Addison's Disease (Chronic Adrenal Insufficiency)	<input type="checkbox"/>	<input type="checkbox"/>
Growth Hormone Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Other Thyroid/Endocrine system disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
3. High Blood Pressure/Hypertension	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

THREE recent blood pressure readings in systolic/diastolic format

Systolic	Diastolic	Date Taken

Readings taken while on meds for hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed with malignant hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Has the diagnosis of hypertension required:		
An ER visit?	<input type="checkbox"/>	<input type="checkbox"/>
A hospital stay?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Which type of aneurysm?		
<input type="checkbox"/> Abdominal/Descending Thoracic Aortic <input type="checkbox"/> Brain		
<input type="checkbox"/> Femoral/Peripheral <input type="checkbox"/> Other type		
Has aneurysm been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
If NO, any further problems?	<input type="checkbox"/>	<input type="checkbox"/>
Hypercholesterolemia/Hyperlipidemia/High blood lipids/High blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
What are cholesterol levels (in mg/dl)?		
<input type="checkbox"/> <=220 <input type="checkbox"/> >220<=250		
<input type="checkbox"/> >250<=300 <input type="checkbox"/> >300		
Are above levels while on cholesterol meds?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
What type of anemia do you/family member have?		
<input type="checkbox"/> Unknown/Other <input type="checkbox"/> Thalassemia Major		
<input type="checkbox"/> Pernicious <input type="checkbox"/> Iron Deficiency		
<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Hemolytic Anemia		
If hemolytic, have you/family member had a splenectomy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Bleeding disorders/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Coronary Artery Disease/Heart Attack/Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had?		
<input type="checkbox"/> Angioplasty/Balloon/Stent Procedure - How many? _____		
<input type="checkbox"/> Cardiac Bypass Surgery		
<input type="checkbox"/> Neither Angioplasty nor Bypass Surgery		
If performed, date procedure done: (MM/YYYY) _____/_____/_____		
If history of heart attacks, give date: (MM/YYYY) _____/_____/_____		
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Is the only treatment drug therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had any hospitalizations for?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomegaly/Enlarged heart	<input type="checkbox"/>	<input type="checkbox"/>
Are you/family member a heart transplant candidate?	<input type="checkbox"/>	<input type="checkbox"/>
Is the reason for the enlargement known?	<input type="checkbox"/>	<input type="checkbox"/>
If known, describe: _____		
Do you/family member have any impairment from condition?		
Peripheral Vascular Disease/Claudication	<input type="checkbox"/>	<input type="checkbox"/>
Is diagnosis?		
<input type="checkbox"/> Reynaud's Disease		
<input type="checkbox"/> Buerger's Disease		
<input type="checkbox"/> Neither Reynaud's or Buerger's		
Cerebral Vascular Accident (CVA)/Stroke/Transient Ischemic Attack (TIA)/Small Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Was diagnosis CVA or TIA? <input type="checkbox"/> CVA <input type="checkbox"/> TIA		
Date symptoms began: (MM/YYYY) _____/_____/_____		
Any residual impairment?	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias/Atrial Fibrillation/Rhythm Problem	<input type="checkbox"/>	<input type="checkbox"/>
Episodes are: <input type="checkbox"/> Single <input type="checkbox"/> Multiple <input type="checkbox"/> Chronic		
If multiple, are they controlled?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, are they controlled by?		
<input type="checkbox"/> Drugs <input type="checkbox"/> Surgical device		
Conduction disturbances/Bundle Branch Blocks	<input type="checkbox"/>	<input type="checkbox"/>
Cause known for conduction disturbances?	<input type="checkbox"/>	<input type="checkbox"/>
If cause known, describe: _____		
Cardiac implantable device/pacemaker installed?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____/_____		
Chest pain/Angina/Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Is clinical work up suggestive of coronary artery disease/blocked cardiac arteries?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date of symptoms onset: (in MM/YYYY) _____/_____/_____		
Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member currently have one of these conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had?		
<input type="checkbox"/> Single episode <input type="checkbox"/> Multiple episodes		
If single episode, date of onset of symptoms: (MM/YYYY) _____/_____/_____		
If multiple, date recovered from last episode: (MM/YYYY) _____/_____/_____		
Are you/family member on anti-clotting RX?	<input type="checkbox"/>	<input type="checkbox"/>
Edema/Swelling of the extremities	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member know what is causing swelling?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, describe: _____		

	YES	NO
Cardiac Valve disorders/Heart Murmur/Valve Prolapse/Regurgitation/Stenosis of Valve	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, was the valve: <input type="checkbox"/> Repaired <input type="checkbox"/> Replaced		
If YES, date of surgery: (MM/YYYY) _____/_____/_____		
If NO, are you/family member symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Artery Occlusion	<input type="checkbox"/>	<input type="checkbox"/>
Is disease symptomatic and documented?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery to correct?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____/_____		
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
Are you/family member on the waiting list for heart transplant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member know what is causing cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, describe: _____		
Pericarditis	<input type="checkbox"/>	<input type="checkbox"/>
Did you/family member have surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If surgery, date of surgery: (MM/YYYY) _____/_____/_____		
Other disease of the heart or circulatory system	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
5. Respiratory/Lung Disorder/Asthma/TB/COPD	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member have?		
<input type="checkbox"/> Asthma & Allergies		
<input type="checkbox"/> Allergies Only <input type="checkbox"/> Asthma Only		
If allergies, are you/family member on desensitization shots?	<input type="checkbox"/>	<input type="checkbox"/>
If asthma, are attacks occasional or frequent?		
<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent		
If asthma, any hospitalizations for?	<input type="checkbox"/>	<input type="checkbox"/>
If asthma, nebulizer used for acute episodes?	<input type="checkbox"/>	<input type="checkbox"/>
If asthma, are you/family member taking corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>
Is asthma under control with medications?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Lung Disease (COPD) or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
If YES, do you/family member have a C-Pap machine?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, has it been recommended by a health care provider that you/family member get a C-Pap machine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____/_____		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
In last two years number of hospitalizations for bronchitis?		
<input type="checkbox"/> Not at all <input type="checkbox"/> One time <input type="checkbox"/> > Than once		
Pulmonary Embolism/Pulmonary Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Is it known what caused embolism/infarction?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

Single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Are you/family member continuing anticoagulant drug treatment?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Have you/family member fully recovered?	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea/Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Known underlying condition causing this?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe underlying condition: _____		
Is the shortness of breath exercise induced?	<input type="checkbox"/>	<input type="checkbox"/>
How would you/family member characterize symptoms? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Pulmonary Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Are you/family member a recipient/candidate for a lung transplant?	<input type="checkbox"/>	<input type="checkbox"/>
Other respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

6. Ear/Eye/Nose/Throat/Skin Disorder	YES	NO
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If YES, list family member(s) affected: _____

Middle ear infections/tubes in ears/Otitis Media	<input type="checkbox"/>	<input type="checkbox"/>
Are infections chronic?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been more than one infection?	<input type="checkbox"/>	<input type="checkbox"/>
Are tubes present in ear canals?	<input type="checkbox"/>	<input type="checkbox"/>
Date of most recent episode: (MM/YYYY) _____/_____		
Any hearing impairment?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, does it require a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, do you/family member need a cochlear implant?	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Both eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
If YES, provide current ocular pressure: _____		
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Date of last episode of symptoms: (MM/YYYY) _____/_____		
Psoriasis/Chronic Skin Condition/Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Episodes are: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Taking Enbrel/Other Biologic RX injections for?	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Cellulitis-skin infection	<input type="checkbox"/>	<input type="checkbox"/>
More than one episode?	<input type="checkbox"/>	<input type="checkbox"/>
Are the episodes severe?	<input type="checkbox"/>	<input type="checkbox"/>
When was since last episode? (MM/YYYY) _____/_____		
Sinusitis/Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Is condition chronic?	<input type="checkbox"/>	<input type="checkbox"/>
How many infections do you/family member have a year? _____		
Other Ear/Eye/Nose/Throat or Skin condition	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/Polyps/Hepatitis/Cirrhosis	YES	NO
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If YES, list family member(s) affected: _____

GERD/Gastroesophageal Reflux Disease/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Did symptoms abate/improve with drug therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Are drugs you/family member taking prescribed by physician?	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Crohn's Disease/Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, what kind of surgery was done?		
<input type="checkbox"/> Partial bowel resection		
<input type="checkbox"/> Total bowel resection		
If YES, date of surgery: (MM/YYYY) _____/_____		
Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Currently under treatment		
<input type="checkbox"/> Single Attack in the past		
<input type="checkbox"/> Multiple Attacks in the past		
If multiple date of last episode of symptoms: (MM/YYYY) _____/_____		
Gastrointestinal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
When was last bleeding episode? (MM/YYYY) _____/_____		
Are you/family member currently under treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis of the Liver/Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Which type of liver disease has been diagnosed?		
<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis C		
<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Alcoholic Hepatitis		
<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Chronic Hepatitis		
If Hepatitis A, B or C - Normal liver function tests?	<input type="checkbox"/>	<input type="checkbox"/>
If Hepatitis C - Taking Interferon by injection?	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Disease/Cholelithiasis/Cholecystitis	<input type="checkbox"/>	<input type="checkbox"/>
Was it a single attack of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Has the gall bladder been removed?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
If NO, date of last attack of symptoms? (MM/YYYY) _____/_____		
Fatty Liver (NASH)	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis/Chronic Inflammation of Colon	<input type="checkbox"/>	<input type="checkbox"/>
Single or multiple episodes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
If YES, are you/family member on prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, is condition under control?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, are you/family member taking steroid medication?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date last episode of symptoms: (MM/YYYY) _____/_____		
Diverticulitis/Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member currently have symptoms from this?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Colon Polyps/Rectal Polyps	<input type="checkbox"/>	<input type="checkbox"/>
Benign?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		

	YES	NO
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
If YES, what kind of hernia?		
<input type="checkbox"/> Inguinal <input type="checkbox"/> Femoral		
<input type="checkbox"/> Scrotal <input type="checkbox"/> Ventral		
Has it been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If no, any symptoms from?	<input type="checkbox"/>	<input type="checkbox"/>
If no operation and symptomatic, are symptoms managed by medicine?	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
Is condition chronic or acute?	<input type="checkbox"/>	<input type="checkbox"/>
Any history of alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>
Any subsequent liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
Single episode of pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member currently have this condition?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date of last episode of symptoms: (MM/YYYY) _____/_____		
Other digestive/intestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

8. Prostate/Reproductive Organ Disorder/Infertility/ STD	YES	NO
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If YES, list family member(s) affected: _____

Uterine fibroids/Dysfunctional Uterine Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Was there a malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
Benign Prostatic Hypertrophy/Prostatic Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Is there a malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had prostate surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Any symptoms or voiding difficulties related to prostatic enlargement?	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Which type?		
<input type="checkbox"/> Genital Herpes-Date of last episode: (MM/YYYY) _____/_____		
<input type="checkbox"/> Chlamydia - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gonorrhea - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Syphilis - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Venereal Warts - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
If YES, are you/family member on infertility treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Are the cysts benign?	<input type="checkbox"/>	<input type="checkbox"/>
Any symptoms from condition?	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Dysplasia/Abnormal Pap Smears	<input type="checkbox"/>	<input type="checkbox"/>
More than one abnormal Pap in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Prolapsed Uterus	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery to correct?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Do you/family member have a history of complications of pregnancies or deliveries?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had an infant that was premature?	<input type="checkbox"/>	<input type="checkbox"/>
With congenital abnormalities/anomalies/defects?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		
Other disorder/abnormality of the reproductive system	<input type="checkbox"/>	<input type="checkbox"/>

Please describe: _____

9. Urinary Tract/Kidney or Renal Disease	YES	NO
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If YES, list family member(s) affected: _____

Cystitis/Urinary Tract Infection (UTI)/Pyuria/Urethritis	<input type="checkbox"/>	<input type="checkbox"/>
Single episode?	<input type="checkbox"/>	<input type="checkbox"/>
When was last episode (in MM/YYYY)? _____/_____		
Was there any protein/discharge/blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>
Cystic disease of kidneys	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Solitary Cyst <input type="checkbox"/> Polycystic		
Have you/family member had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Have you had a kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY) _____/_____		
Any post-surgical complications?	<input type="checkbox"/>	<input type="checkbox"/>
Renal calculi/Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date of last episode: (MM/YYYY) _____/_____		
More than two episodes of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Were stones in one or both kidneys?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unilateral/One kidney only		
<input type="checkbox"/> Bilateral/Both kidneys		
Interstitial cystitis	<input type="checkbox"/>	<input type="checkbox"/>
Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date of last episode: (MM/YYYY) _____/_____		
Acute Renal failure/Chronic Renal failure	<input type="checkbox"/>	<input type="checkbox"/>
Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date of recovery: (MM/YYYY) _____/_____		
Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Other Kidney/Urinary tract disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

10. Nervous System/Brain Disorder/Headache/ Epilepsy/Seizure Disorder	YES	NO
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If YES, list family member(s) affected: _____

Headaches/Migraines/Cluster Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Situational Headaches (menstrual, stress, other)?	<input type="checkbox"/>	<input type="checkbox"/>
Characterization of severity & frequency of headaches (Pick one):		
<input type="checkbox"/> Mild and/or less than 5/year <input type="checkbox"/> Severe and/or > 10/year		
<input type="checkbox"/> Moderate and/or 5 - 10/year <input type="checkbox"/> Onset less than 6 months		
Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Was there a loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, how long was loss of consciousness?		
<input type="checkbox"/> < 1 hour <input type="checkbox"/> < 1 day <input type="checkbox"/> More than 1 day		
If < 1 hour, any residual problems post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
If < 1 day, give date of recovery: (MM/YYYY) _____/_____		
If < 1 day, any residual problems post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis/Encephalomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, any residual complications post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, how long since recovery (in MM/YYYY)? _____/_____		
Neuroma/Abnormal Nerve Growth	<input type="checkbox"/>	<input type="checkbox"/>
Is growth benign?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, when was surgery (MM/YYYY)? _____/_____		

	YES	NO
If NO, when was recovery (MM/YYYY)?	____/____	
Is the diagnosis Morton's Neuroma?	<input type="checkbox"/>	<input type="checkbox"/>
Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Reflex Sympathetic Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
If YES, have currently or recovered from?		
<input type="checkbox"/> Current <input type="checkbox"/> Recovered from		
If recovered, date of recovery: (MM/YYYY)	____/____	
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
If YES, have currently or recovered from?		
<input type="checkbox"/> Currently have <input type="checkbox"/> Recovered from		
If recovered, date of recovery: (MM/YYYY)	____/____	
Peripheral Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Is another disease condition causing neuropathy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please describe: _____		
<hr/>		
Epilepsy/Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member know what type of seizure has been diagnosed?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, what is seizure type?		
<input type="checkbox"/> Febrile <input type="checkbox"/> Petit Mal <input type="checkbox"/> Jacksonian		
<input type="checkbox"/> Grand Mal <input type="checkbox"/> Focal		
Is another disease condition causing seizures?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please describe: _____		
<hr/>		
Heat Exhaustion/Heat Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Which diagnosis? <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Heat Stroke		
Single episode?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date of last episode: (MM/YYYY)	____/____	
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis/Hemiplegia/Paraplegia	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Viral Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Motor Neuron Disease	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia/Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Other disorder of the nervous system	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
11. Mental or Psychiatric Condition/Depression/ Behavioral (e.g., Attention-Deficit Hyperactivity Disorder) or Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Affective Disorders YES NO

What is diagnosis (pick one below)?

Obsessive Compulsive Disorder (OCD) Agoraphobia

Panic Disorder Neuroses

Anxiety Disorder

Is treatment effective? YES NO

If YES, date treatment became effective? (MM/YYYY) _____/_____

What is characterization of severity of symptoms?

Mild Moderate Severe

	YES	NO
Schizophrenia/Paranoia	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder/Bulimia/Anorexia	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member currently have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
When was recovery? (MM/YYYY)	____/____	
Attention Deficit Disorder/ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
What is characterization of severity of symptoms?		
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Are symptoms controlled by medication?	<input type="checkbox"/>	<input type="checkbox"/>
Situational Depression/Mild Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Is only current treatment prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>
Major Depression/Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
When was diagnosis made? (MM/YYYY)	____/____	
Have you/family member ever sought, or are you seeking professional counseling/therapy for a mental health issue?	<input type="checkbox"/>	<input type="checkbox"/>
Date of last treatment? (MM/YYYY)	____/____	
Other mental health/psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Cervical (Neck) or Thoracic (Mid Back) or Lumbar (Low Back) Disc Herniation or Protrusion YES NO

Are you/family member under current treatment for?

Have you/family member had surgery for condition?

If YES, any subsequent problems post-op?

If YES, date of surgery: (MM/YYYY) _____/_____

If no surgery was done, have you/family member recovered?

If you/family member have recovered, date of Recovery: (MM/YYYY) _____/_____

Low Back Pain/Lumbago/SI Joint/Sciatica YES NO

Are you/family member under current treatment for?

If not in current treatment, date of last episode: (MM/YYYY) _____/_____

Spinal Fractures YES NO

Any lingering neurological defects?

Was fracture a compression fracture?

When was last treatment (in MM/YYYY)? _____/_____

Spinal Stenosis YES NO

Have you/family member had surgery for condition?

If YES, date of surgery: (MM/YYYY) _____/_____

Low Back Strain/Whiplash/Muscle Spasm YES NO

Are you/family member under current treatment for?

Ankylosing Spondylitis/Spondylolisthesis YES NO

Have you/family member had surgery for condition?

If YES, date of surgery: (MM/YYYY) _____/_____

If NO, is condition symptomatic/requiring treatment?

Sciatica/Radiculitis/Radiating pain to legs or arms YES NO

Do you/family member have any neurological defects?

Are you/family member currently under treatment for?

Are episodes recurrent?

When was last episode (in MM/YYYY)? _____/_____

Spinal deformities/Scoliosis/Lordosis YES NO

	YES	NO
Have you/family member had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If surgery, any continuing problems post-op?	<input type="checkbox"/>	<input type="checkbox"/>
If surgery was done, date of surgery: (MM/YYYY)	____/____	
If no surgery, are you/family member currently under treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If you/family member are currently under treatment, is condition?		
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
If no current treatment, date of last treatment? (MM/YYYY)	____/____	
Spina Bifida/Myelocele	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____	
If YES, any residual neurological defects?	<input type="checkbox"/>	<input type="checkbox"/>
Other back/neck disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disease/TMJ	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Kinds of arthritis do you/family member have?		
<input type="checkbox"/> Degenerative <input type="checkbox"/> Chronic proliferative		
<input type="checkbox"/> Hypertrophic <input type="checkbox"/> Arthritis deformans		
<input type="checkbox"/> Senile <input type="checkbox"/> Psoriatic		
<input type="checkbox"/> Juvenile Rheumatoid <input type="checkbox"/> Chondrocalcinosis		
<input type="checkbox"/> Adult Rheumatoid <input type="checkbox"/> Septic		
<input type="checkbox"/> Atrophic <input type="checkbox"/> Acute Infectious		
<input type="checkbox"/> Osteoarthritis		
Is condition asymptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
If symptomatic, date of first onset of symptoms: (MM/YYYY)	____/____	
Is more than one joint affected?	<input type="checkbox"/>	<input type="checkbox"/>
If no, is the joint a hip or knee?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had a hip/knee replacement?	<input type="checkbox"/>	<input type="checkbox"/>
If you/family member had surgery, date of surgery: (MM/YYYY)	____/____	
Characterization of disease progression/degree of disability:		
<input type="checkbox"/> Mild, Minimal <input type="checkbox"/> Moderate to Severe		
Is there a joint infection?	<input type="checkbox"/>	<input type="checkbox"/>
Osteomyelitis/Bone Infection/Bone Abscess	<input type="checkbox"/>	<input type="checkbox"/>
Was there only a single episode?	<input type="checkbox"/>	<input type="checkbox"/>
Involved joint/bone was:		
<input type="checkbox"/> Major joint/bone <input type="checkbox"/> Minor joint/bone		
TMJ Disorder/Disease	<input type="checkbox"/>	<input type="checkbox"/>
TMJ Syndrome/Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>
Under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date treatment completed: (MM/YYYY)	____/____	
Bursitis/Tennis Elbow/Tendonitis/Synovitis	<input type="checkbox"/>	<input type="checkbox"/>
Was there only a single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Is underlying cause known for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please describe cause for condition below:		

Any symptoms from?	<input type="checkbox"/>	<input type="checkbox"/>
Any subsequent fractures?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Do you/family member take steroids for condition?	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____	
Ligament tears/Torn Meniscus/Osteochondritis/Dessicans/Chondromalacia	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If surgery, date of surgery: (MM/YYYY)	____/____	
Bone dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Was the dislocation (choose one, below)?		
<input type="checkbox"/> Congenital hip <input type="checkbox"/> Patella (kneecap)		
<input type="checkbox"/> Shoulder <input type="checkbox"/> Knee (not kneecap)		
<input type="checkbox"/> Hip-traumatic <input type="checkbox"/> Other joint-traumatic		
Was there a single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member currently have?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____	
Dislocation was:		
<input type="checkbox"/> Unilateral/one sided <input type="checkbox"/> Bilateral/both sides		
Bone fracture	<input type="checkbox"/>	<input type="checkbox"/>
Has treatment been completed?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____	
Was the fracture? <input type="checkbox"/> Union <input type="checkbox"/> Non-Union		
Was the fracture of?		
<input type="checkbox"/> Leg/hip/foot		
<input type="checkbox"/> Arm/hand/shoulder		
<input type="checkbox"/> Other bone		
Foot pain	<input type="checkbox"/>	<input type="checkbox"/>
Bunions	<input type="checkbox"/>	<input type="checkbox"/>
If YES, have you/family member had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____	
Plantar fasciitis	<input type="checkbox"/>	<input type="checkbox"/>
Rotator cuff tear	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____	
Date of original injury: (MM/YYYY)	____/____	
Gout/Gouty Arthritis/Hyperuricemia	<input type="checkbox"/>	<input type="checkbox"/>
Characterization of number of attacks:		
<input type="checkbox"/> Few <input type="checkbox"/> Frequent		
Are attacks well controlled by medication/diet?	<input type="checkbox"/>	<input type="checkbox"/>
Other bone/joint disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
14. Muscular Disorder/Lupus/Connective Tissue/Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Collagen diseases:Scleroderma/Ehlers-Danlos Syndrome/Mixed Connective Tissue disease/Necrotizing Angiitis	<input type="checkbox"/>	<input type="checkbox"/>
Lupus Erythematosus	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia/Myitis/Myositis	<input type="checkbox"/>	<input type="checkbox"/>
Currently being treated?	<input type="checkbox"/>	<input type="checkbox"/>
If no current treatment, date of recovery: (MM/YYYY)	____/____	
Recurrent episodes?	<input type="checkbox"/>	<input type="checkbox"/>
Polymyositis/Neuromyositis/Dermatomyositis	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Autoimmune Disorder/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		
Ligament tears/Meniscus tears/Osteochondritis/		
Dessicans/Chondromalacia	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If surgery, date of surgery: (MM/YYYY)	____/____/____	
Other Muscle/Connective Tissue/Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

15. Cancer/Tumors/Cysts/Neoplasm	YES	NO
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If YES, list family member(s) affected: _____

Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell/Squamous Cell Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lipoma/Adipose Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Colon/Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Other kind of cancer	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		
Are you/family member under current treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If NO, date treatment completed: (MM/YYYY) ____/____/____		
What was stage of the tumor?		
<input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV		
When diagnosed? (in MM/YYYY) ____/____/____		
Was the treatment surgery alone? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If YES, date of surgery: (MM/YYYY) ____/____/____		
If not, what were the other treatments? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Please describe: _____		
Is cancer in remission? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is the cancer metastatic? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is the cancer recurrent? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you/family member been told you have an abnormal, suspicious lesion/possible pre-malignant condition? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Has the lesion been removed? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Cyst <input type="checkbox"/> YES <input type="checkbox"/> NO		
Please describe: _____		
Has the cyst been removed? <input type="checkbox"/> YES <input type="checkbox"/> NO		

16. Have you or any family member applying for coverage been positively diagnosed or treated for HIV/AIDS/ARC Chronic or Infectious Disease ?	YES	NO
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If YES, list family member(s) affected: _____

HIV (human immunovirus) – Positively diagnosed/treated	<input type="checkbox"/>	<input type="checkbox"/>
AIDS (Acquired Immune Deficiency Syndrome) – Positively diagnosed/treated	<input type="checkbox"/>	<input type="checkbox"/>
ARC (AIDS related complex) – Positively diagnosed/treated	<input type="checkbox"/>	<input type="checkbox"/>
Other chronic or Infectious disease	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

17. Any other Illness, Disease, Condition or Injury	YES	NO
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If YES, list family member(s) affected: _____

As a result of an injury or illness have you/family member had any of the treatments listed below?

Bone or skin graft(s)	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Loss of limb	<input type="checkbox"/>	<input type="checkbox"/>
Loss or surgical removal of organ	<input type="checkbox"/>	<input type="checkbox"/>

If YES, please describe: _____

Other Disease/Disease Condition/Disorder/Injury not previously described YES NO

Please describe: _____

Date of last treatment (in MM/YYYY): ____/____/____

Treating Physician: _____