

HEALTH INSURANCE ASSESSMENT QUESTIONNAIRE

Applicant Name: _____	D.O.B _____	Height _____	Weight _____
Spouse Name: _____	D.O.B _____	Height _____	Weight _____
Child Name: _____	D.O.B _____	Height _____	Weight _____
Child Name: _____	D.O.B _____	Height _____	Weight _____
Child Name: _____	D.O.B _____	Height _____	Weight _____
Child Name: _____	D.O.B _____	Height _____	Weight _____

Is any family member planning or scheduled for:

Hospitalization Yes <input type="checkbox"/> No <input type="checkbox"/>	Therapy (any type) Yes <input type="checkbox"/> No <input type="checkbox"/>
Surgery Yes <input type="checkbox"/> No <input type="checkbox"/>	Counseling (any type) Yes <input type="checkbox"/> No <input type="checkbox"/>
Medical Treatment Yes <input type="checkbox"/> No <input type="checkbox"/>	Medical Testing Yes <input type="checkbox"/> No <input type="checkbox"/>

Is any family member pregnant? Yes No

If so, when is the due date? _____

Have there been any complications (if so, please provide details)? _____

In the past 5 years, has any family member had surgery, been hospitalized or treated, received blood tests or other diagnostic tests, or been advised to receive treatment for any of the following conditions:

Arthritis/Bone/Joint/Muscle Yes <input type="checkbox"/> No <input type="checkbox"/>	AIDS/HIV Yes <input type="checkbox"/> No <input type="checkbox"/>	
Allergy/Asthma/Respiratory Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer Yes <input type="checkbox"/> No <input type="checkbox"/>	
Digestive/Intestinal/Eating Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumor Yes <input type="checkbox"/> No <input type="checkbox"/>	
Skin/Eye/Ear/Nose/Throat Yes <input type="checkbox"/> No <input type="checkbox"/>	Infertility Yes <input type="checkbox"/> No <input type="checkbox"/>	
Kidney/Bladder/Urinary Yes <input type="checkbox"/> No <input type="checkbox"/>	Endocrine Yes <input type="checkbox"/> No <input type="checkbox"/>	
Stroke/Neurological/Nervous Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcohol/Drug Use Yes <input type="checkbox"/> No <input type="checkbox"/>	
Diabetes - last HbA1c reading & date Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver/Hepatitis Yes <input type="checkbox"/> No <input type="checkbox"/>	
High Blood Pressure - last reading & date Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart/Circulatory Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Mental/Nervous Yes <input type="checkbox"/> No <input type="checkbox"/>	

Please list any other medical conditions not stated above:

Have you smoked cigarettes or used tobacco of any kind in the last 12 months? Yes No

List all medications taken and dosages:

Name _____	Name _____
Medication _____	Medication _____

Please explain answers to any questions you checked "yes" to above:

Name: _____

Diagnosis of Condition: _____

Duration of Condition: _____

Type of Treatment: _____

Medications: _____

Any Current Symptoms/problems: _____

Name: _____

Diagnosis of Condition: _____

Duration of Condition: _____

Type of Treatment: _____

Medications: _____

Any Current Symptoms/problems: _____