



CONFIDENTIAL MEDICAL INFORMATION SURVEY FORM

NAME OF PERSONS TO BE COVERED	RELATION	GENDER	DATE OF BIRTH MM/DD/YYYY	AGE	HEIGHT FT IN	WEIGHT	SSN
	APPLICANT						
	SPOUSE						
	CHILD #1						
	CHILD #2						
	CHILD #3						

Address: _____ City: _____ Zip: _____

Email Address: _____ County: _____

Phone: _____ Marital Status _____ Marriage Date: _____

Full Time Hire Date (Group Applicants) _____ Occupation _____ Annual Household Earnings (Individual Applicants) _____

	PRIMARY DOCTOR	PRIMARY DOCTOR	PRIMARY DOCTOR	PRIMARY DOCTOR
NAME				
ADDRESS				
PHONE				
	SPECIALIST	SPECIALIST	SPECIALIST	SPECIALIST
NAME				
ADDRESS				
PHONE				

Have **YOU** or any of your listed **DEPENDENTS** been diagnosed in the past or are currently being treated by a physician for any of the following conditions?

CONDITIONS	YES	NO	CONDITIONS	YES	NO
1. AIDS, AIDS Related Complex, or HIV Positive			21. Heart Attack, Congestive Heart Failure, Aneurysm, Angina, or other heart disease or disorder		
2. Arthritis, Gout, Lupus, or joint pain			22. Multiple Sclerosis, Convulsions, Epilepsy, Parkinson's Disease, or other nervous system disease or disorder		
3. Abnormal Pap Test, Endometriosis, Infertility, Pelvic Inflammatory Disease, Sexually Transmitted Disease, or other disease or disorder of the reproductive system			23. High Blood Pressure or high cholesterol		
4. Alcohol, Drug Abuse/Dependency			24. Kidney Disease or Disorder		
5. Alzheimer's Disease			25. Mental or behavioral disorders, anxiety, depression, attempted suicide		
6. Anemia, Hemophilia, other blood disease, or disorder			26. Muscular Dystrophy or Cerebral Palsy		
7. Anorexia, Bulimia, Obesity, or Gastric Bypass			27. Are you or any of your dependents currently pregnant? If Yes, expected due date:		
8. Asthma, Chronic Bronchitis, Cystic Fibrosis, Emphysema, Pneumonia, or Tuberculosis			28. Organ Transplant of any kind		
9. Back, Neck, Spine, or bone disease or disorder			29. Pancreas disease or disorder		
10. Birth defects, Downs Syndrome, Spina Bifida, or other deformity or handicap			30. Paralysis, Paraplegia, Quadriplegia		
11. Bladder/urinary system disease or disorder			31. Skin disease or disorder		
12. Brain disease or disorder, concussion/head injury, or migraines			32. Testicular or Prostate disease or disorder		
13. Breast augmentation or reduction, lump, disease/disorder			33. Thyroid or glandular disease or disorder, disease of lymph nodes		
14. Cancer, Lymphoma, Hodgkin's Disease, Leukemia, Melanoma, or malignancy			34. Vascular disease, Varicose veins, Phlebitis, Stroke, or other blood vessel or circulatory disease or disorder		
15. Cataracts, Glaucoma, other eye diseases or disorders			35. In the past 10 years, have you or your dependents ever had or ever been treated for, or been told that you have a condition, disease or disorder not listed in #1-#35. (If Yes, please indicate on back)		
16. Cysts, tumors, or growths			36. In the past ten years, have you or your dependents been hospitalized, or had surgery, or been advised to have a procedure which was not performed?		
17. Cirrhosis, Hepatitis, Jaundice, or other diseases or disorders of the liver			37. Are you, or any of your dependents, currently taking prescription medication? (If Yes, indicate MEDICATION and DOSAGE on back)		
18. Colitis, Crohn's Disease, Diverticulitis, Gallbladder, Ulcers, or other intestinal disease or disorder			38. Have you or any of your dependents been on early Medicare, Disability, or Worker's Compensation?		
19. Diabetes (If Yes, indicate Type 1 or Type 2)			39. Have you or any of your dependents been declined for Life or Health Insurance coverage?		
20. Amputations, Prosthetics			40. Do you or any dependent currently use tobacco? (If Yes, please indicate the name and length of product use)		

