

Informal Medical History Evaluation Form

LIST BELOW ALL INDIVIDUALS TO BE COVERED

	Name	Birth Date	Sex	Smoker	Height	Weight
Self						
Spouse						
1						
2						
3						
4						

Medical Information

- 1 Are you, your spouse , or any listed dependent currently pregnant, or an expectant parent?
- 2 Are you, your spouse, or any listed dependent currently taking any prescription medications?
- 3 Has any insurance company refused or restricted any health coverage on any person listed on this application within the last five (5) years? If yes, indicate for what below.
- 4 Do you, your spouse or any listed dependent have a condition covered by Workers' Compensation?
If yes, please provide details including the Workers' Comp. Number below
- 5 In the past three years, have you, your spouse, or any listed dependent engaged in sports or hobbies such as scuba diving, automobile or motorcycle racing, skydiving or aero sports on a regular/ routine basis?
- 6 Have you, your spouse, or any listed dependent within the last five years been treated for, diagnosed as having, has been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advice for any of the following conditions?

Condition	Yes	Condition	Yes	Condition	Yes
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- | | | |
|---|--|--|
| 1 Abnormal Pap Smears <input style="float: right;" type="checkbox"/> | 22 Coronary Artery Disease <input style="float: right;" type="checkbox"/> | 40 High Blood Pressure <input style="float: right;" type="checkbox"/> |
| 2 AIDS, ARC or HIV <input style="float: right;" type="checkbox"/> | 23 Cystic Fibrosis <input style="float: right;" type="checkbox"/> | Last 3 Pressures & Dates: |
| 3 Allergies <input style="float: right;" type="checkbox"/> | 24 Depression <input style="float: right;" type="checkbox"/> | 1) _____ |
| 4 Alzheimer's Disease <input style="float: right;" type="checkbox"/> | 25 Diabetes <input style="float: right;" type="checkbox"/> | 2) _____ |
| 5 Aneurysm <input style="float: right;" type="checkbox"/> | Last 3 Blood Sugars & Dates: | 3) _____ |
| 6 Arthritis <input style="float: right;" type="checkbox"/> | 1) _____ | 41 Hyperthyroidism <input style="float: right;" type="checkbox"/> |
| 7 Asthma <input style="float: right;" type="checkbox"/> | 2) _____ | 42 Hysterectomy <input style="float: right;" type="checkbox"/> |
| 8 Back Strain <input style="float: right;" type="checkbox"/> | 3) _____ | 43 Kidney Failure <input style="float: right;" type="checkbox"/> |
| 9 Bronchitis, Chronic <input style="float: right;" type="checkbox"/> | 26 Diverticulitis/ Diverticulitis <input style="float: right;" type="checkbox"/> | 44 Kidney Stones <input style="float: right;" type="checkbox"/> |
| 10 Cancer <input style="float: right;" type="checkbox"/> | 27 Down's Syndrome <input style="float: right;" type="checkbox"/> | 45 Lou Gehrig's Disease <input style="float: right;" type="checkbox"/> |
| (Date Last Treated _____) <input style="float: right;" type="checkbox"/> | 28 Endometriosis <input style="float: right;" type="checkbox"/> | 46 Mental Health Disorders <input style="float: right;" type="checkbox"/> |
| 11 Carpel Tunnel Syndrome <input style="float: right;" type="checkbox"/> | 29 Epilepsy <input style="float: right;" type="checkbox"/> | 47 Migraines <input style="float: right;" type="checkbox"/> |
| 12 Cataracts <input style="float: right;" type="checkbox"/> | 30 Fibrocystic Breast Disease <input style="float: right;" type="checkbox"/> | 48 Ovarian Cyst <input style="float: right;" type="checkbox"/> |
| 13 Cerebral Palsy <input style="float: right;" type="checkbox"/> | 31 Fibromyalgia <input style="float: right;" type="checkbox"/> | 49 Parkinson's Disease <input style="float: right;" type="checkbox"/> |
| 14 Chemical Dependency <input style="float: right;" type="checkbox"/> | 32 Gallbladder Disease <input style="float: right;" type="checkbox"/> | 50 Prostate Disorders <input style="float: right;" type="checkbox"/> |
| 15 Cholesterol <input style="float: right;" type="checkbox"/> | 33 Gastric Reflux <input style="float: right;" type="checkbox"/> | 51 Stroke (Date: _____) <input style="float: right;" type="checkbox"/> |
| 16 Chronic Obstructive Pulmonary <input style="float: right;" type="checkbox"/> | 34 Gout <input style="float: right;" type="checkbox"/> | 52 Systemic Lupus <input style="float: right;" type="checkbox"/> |
| Disease <input style="float: right;" type="checkbox"/> | 32 Graves Disease <input style="float: right;" type="checkbox"/> | 53 Thyroid Disorder <input style="float: right;" type="checkbox"/> |
| 18 Crohns Disease <input style="float: right;" type="checkbox"/> | 36 Heart Attack <input style="float: right;" type="checkbox"/> | 54 TMJ <input style="float: right;" type="checkbox"/> |
| 19 Colitis <input style="float: right;" type="checkbox"/> | 37 Heart Bypass <input style="float: right;" type="checkbox"/> | 55 Transient Ischemic Attacks <input style="float: right;" type="checkbox"/> |
| 20 Congenital Disorders <input style="float: right;" type="checkbox"/> | 38 (Date: _____) <input style="float: right;" type="checkbox"/> | 56 Varicose Veins <input style="float: right;" type="checkbox"/> |
| 21 Congestive Heart Failure <input style="float: right;" type="checkbox"/> | 39 Heart Murmur <input style="float: right;" type="checkbox"/> | 57 Other Conditions <input style="float: right;" type="checkbox"/> |

If any questions or conditions from above are checked "Yes", please explain below (use additional paper if necessary). Please indicate all details. Include such items as location of condition, diagnosis, type of treatment and hospitalization. Also list any prescribed medications.

Employee Signature _____ Date _____

By signing I attest the information is complete and correct to the best of my knowledge. I also acknowledge this is not an application for insurance coverage, and the information provided will be used to provide an illustration for potential coverage, and is not binding.