



HEALTH HISTORY QUESTIONNAIRES

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HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

GENERAL HEALTH HISTORY QUESTIONNAIRE

1) Condition/Dx: _____

Date of onset/Dx date: _____

2) Tx: _____

3) Name of treating physician: _____

Specialist? Yes No

If yes, type of specialist: _____

4) Fully recovered and released from the doctor's care? Yes No

If not, how often is doctor seen for condition? _____

5) Any residual effects? _____

6) Prognosis: _____

7) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Date of interview: _____ Time: _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

ASTHMA, BRONCHITIS, EMPHYSEMA OR ANY DISEASE OR DISORDER OF THE RESPIRATORY SYSTEM

1) Exact Diagnosis: _____

2) Date of onset or diagnosis: _____

3) Names and dosages of all medications you are taking: _____

4) How many episodes have you had in the past 12 months? _____

5) Have you ever been hospitalized for this? Yes No

If yes, date of hospitalization? From: _____ To: _____

6) How many Emergency Room visits have you had in the past 12 months for this condition?

What type of treatment did you receive in the Emergency Room: _____

7) Do you currently smoke? Yes No Have you smoked in the past? Yes No

If yes, when did you quit? _____

8) Name of the doctor treating you for this condition: _____

9) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

10) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

ARTHRITIS, BACK OR KNEE DISORDER OR ANY DISEASE OR DISORDER OF THE MUSCULOSKELETAL SYSTEM

1) Exact diagnosis: _____

2) Date of onset or diagnosis: _____

3) If arthritis, please indicate the type of arthritis: Rheumatoid Gouty Osteo Psoriatic

4) If Scoliosis, what is the degree of curvature? _____

5) How often do you see the doctor for this? _____

6) When was the last time you were seen for this? _____

7) Names, dosages, and frequency of all medications you are currently taking. Indicate which of these medications are being taken continuously and which are taken as needed: _____ continuously as needed

8) Indicate the type of tests that have been done, the dates, and the results: _____

9) If surgery has been done or is planned, indicate the type of surgery, the date and the results: _____

10) Has this condition caused any deformity? Yes No If yes, please indicate the type and location: _____

11) Are you restricted in any way in movement or activity? Yes No If yes, please explain: _____

12) Is any other type of treatment planned for the future? Yes No If yes, please provide details: _____

13) Have you been released? Yes No If yes, date of release: _____

14) Name of the doctor treating you for this condition? _____

15) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No If yes, please provide dates, reasons, and results: _____

16) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

CANCER, MALIGNANCY, TUMOR, POLYP, CYST OR ANY TYPE OF ABNORMAL GROWTH (If Breast Cancer, use appropriate questionnaire)

1) Exact diagnosis: _____

2) Location: _____

3) Was it: Malignant? Benign?

4) What was the stage or classification? _____

5) Which of the following was done? Surgery Chemo-therapy
 Radiation All of the above

6) Has your doctor released you? Yes No

If yes, what was the date you were released? _____

If no, indicate what, if any, future treatment or tests are indicated: _____

7) Do you currently smoke? Yes No Have you smoked in the past? Yes No

If yes, when did you quit? _____

8) Name of the doctor treating you for this condition: _____

9) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

10) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

COLITIS, IRRITABLE BOWEL, DIVERTICULITIS, DIVERTICULOSIS OR ANY DISEASE OR DISORDER OF THE GASTROINTESTINAL TRACT

1) Exact diagnosis: _____

2) Date of onset or diagnosis: _____

3) How many attacks have you had in the past year? _____

4) Names, dosages, and frequency of all medications you are taking: _____

5) Dates of and types of treatment you have received, other than medication: _____

6) Any surgery completed or planned? Yes No

If yes, provide the type of surgery, the date, and the results: _____

7) Name of the doctor treating you for this condition: _____

8) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

9) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

DIABETES

1) Date of onset or diagnosis: _____

2) How often do you see the doctor for this condition? _____

3) How often do you check your blood sugar? _____

What was your most recent blood sugar reading? _____ Date: _____

What was your most recent HA1C level? _____ Date: _____

4) Are you taking oral medication? Yes No Drug / Dose: _____

Are you taking insulin? Yes No Via injection or Pump? Drug / Units: _____

5) What is the dosage and how many times a day do you take it? _____

6) Has your medication been changed in any way in the past five years? _____

7) Have you ever been hospitalized for your Diabetes? Yes No

If yes, please provide the date(s) and results: _____

8) Have you ever been treated for any of the following?

Diabetic Shock Insulin Reaction Diabetic Coma

Kidney problem Skin Ulcers Polyneuropathy

Diabetic Retinopathy Coronary Artery Disease

If you checked any of the above, provide complete details: _____

9) Have you had many episodes of low blood sugar and if so are you able to feel them come on? Are you able to control the episode on your own? Have you had to seek medical attention during a low blood sugar episode? How many of these episodes have you had within the last year? _____

10) Name of the doctor who is treating your Diabetes: _____

11) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

12) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

DRUG OR ALCOHOL ABUSE INCLUDING PRESCRIPTION DRUG ADDICTIONS

1) Were you diagnosed as: being addicted to alcohol? being addicted to drugs?

2) If your above answer is drugs, please provide the names of the drugs used: _____

3) Date of diagnosis: _____

4) How long have/had you been abusing alcohol or drugs? _____

5) Were you ever hospitalized for this? Yes No
If yes, when and for how long? _____

6) Are you currently participating in a support group? Yes No
If yes, which one? _____ How often do you attend? _____
If no, have you been or are you currently in any type of support counseling? Yes No
If yes, provide the dates and frequency of the counseling: _____

7) Were you ever cited for driving while under the influence? Yes No
If yes, when was the last time? _____

8) Do you have any medical complications as a result of the substance abuse?
(i.e.: Hepatitis, Cirrhosis, HIV Syndrome, etc.) Yes No
If yes, provide the exact diagnosis, details regarding the treatment and the current status of the condition:

9) Please provide the name of the doctor who is treating you for the substance abuse problem:

10) Please provide the name of the doctor who is treating you for the condition listed in #8:

11) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No
If yes, please provide dates, reasons, and results: _____

12) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

ANY DISEASE OR DISORDER OF THE EYES, EARS, NOSE OR THROAT

1) Exact diagnosis: _____

2) Date of onset or diagnosis: _____

3) Names, dosages, and frequency of all medications you are taking: _____

4) Has any surgery been done? Yes No

IF YES, PROVIDE TYPE, DATE, AND RESULTS: _____

5) Describe any visual, hearing, or speech impairment, if any: _____

6) Is future surgery anticipated? Yes No

If yes, provide the type and approximate date it will be done: _____

7) Name of the doctor treating you for this condition: _____

8) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

9) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

EPILEPSY OR ANY SEIZURE DISORDER

1) Date of onset or diagnosis: _____

2) Please indicate the type of seizure you have experienced: Gran Mal – Tonic – Clonic Petit Mal – Absence Psychomotor Complex – partial Myoclonic

3) How often do you have seizures? _____

4) Date of your most recent seizure: _____

5) Names, dosages, and frequency of all medications you are taking: _____

6) Has any surgery been recommended to help control your seizures? Yes No
Details: _____

7) Have you ever been hospitalized for the condition? Yes No
If yes, please provide the date(s) and the length of time you were hospitalized:

8) Name of the doctor treating you for this condition: _____

9) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No
If yes, please provide dates, reasons, and results: _____

10) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

ANY DISEASE OR DISORDER OF THE BREAST OR REPRODUCTIVE ORGANS

1) Exact diagnosis: _____

2) Symptoms: _____

3) Was surgery done? Yes No

If yes, provide the date, type and the results: _____

4) Names, dosages, and frequency of all medications you are currently taking:

5) Any further treatment or surgery anticipated for this condition? _____

6) Name and address of doctor treating you for this condition: _____

7) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results:

8) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

HYPERTENSION OR ANY DISORDER OF THE HEART OR CIRCULATORY SYSTEM

1) Exact diagnosis: _____

2) Date of onset or diagnosis: _____

3) Names and dosages of all medications you are taking: _____

4) Have you ever had any of the following?

- Yes No Heart attack – If yes, provide date and details: _____
 Yes No Stroke or TIA (mini stroke) – If yes, provide date and any residual problems: _____
 Yes No Diabetes
 Yes No Elevated Cholesterol, Triglycerides, or abnormal cholesterol ratio
 Yes No Kidney Disease – If yes, details: _____
 Yes No Enlarged heart
 Yes No Angina or chest pain related to coronary artery disease. Regular nitroglycerine use? _____
 Yes No Peripheral Vascular disease [claudication/calf pain/cramps] or carotid artery stenosis [hardening of the arteries]. If yes, have you had an endarterectomy [surgery] or carotid angioplasty [balloon procedure]? _____
 Yes No Aneurysm – If yes, provide date and treatment details: _____
 Yes No Arrhythmia or palpitations – If yes, has Holter monitoring been done? Results: _____

5) Have you ever had cardiac catheterization? Yes No
Results: _____

6) Have you had a treadmill stress test within the past year? Yes No
Results: _____

7) Have you had an EKG or an echocardiogram within the past year? Yes No
Results: _____

8) Have you had any cardiac surgeries? Yes No
If CABG [grafting] or angioplasty [balloon], how many vessels? _____

9) Most recent blood pressure readings (3):
1. _____/____ Date: _____
2. _____/____ Date: _____
3. _____/____ Date: _____

10) Do you currently smoke? Yes No
Have you been a smoker in the past? Quit Date: _____

11) How many times per week do you exercise and for how long? _____

12) In the past 12 months have you made any noticeable changes in your diet? Yes No
If so, how _____

13) Have you ever consulted a dietician or nutritionist? Yes No

14) Doctor(s) names, specialty, and frequency of visits: _____

15) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No
If yes, please provide dates, reasons, and results: _____

16) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

KIDNEY, BLADDER, PROSTATE OR ANY DISEASE OR DISORDER OF THE URINARY SYSTEM

1) Exact diagnosis: _____

2) Date of onset or diagnosis: _____

3) How many episodes have you had? _____

4) If Kidney Stone, how many were present at the time? _____

Were they present in one kidney or both? _____

5) Names and dosages of all medications you are taking: _____

6) Dates of and types of treatment you have received, other than medication: _____

7) Any surgery completed or planned? Yes No

If yes, provide the type of surgery, the date, and the results: _____

8) Name of the doctor treating you for this condition: _____

9) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

10) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

HEPATITIS A OR B, CIRRHOSIS, FIBROSIS OF THE LIVER OR ANY DISEASE OR DISORDER OF THE LIVER

1) Exact diagnosis: _____

2) Date of onset or diagnosis: _____

3) Names, dosages, and frequency of all medications you are taking: _____

4) If Hepatitis, have you been treated for any secondary conditions? _____

5) How are the above conditions being treated: _____

6) Dates of and types of treatment you have received, other than medication: _____

7) Has a liver biopsy been done or recommended? Yes No

If yes, provide the date of the biopsy and the results: _____

8) Any surgery completed or planned? Yes No

If yes, provide the type of surgery, the date, and the results: _____

9) Name of the doctor treating you for this condition: _____

10) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

11) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

DEPRESSION, ANXIETY, BI-POLAR DISORDER OR ANY MENTAL OR NERVOUS DISORDER

1) Exact diagnosis: _____

2) Date of diagnosis or onset of symptoms: _____

3) Names and dosages of all medications you are taking: _____

4) If depressed, number of episodes including dates or date of last episode: _____

5) Have you ever been treated with ECT ("shock treatment")? Yes No

6) If anxiety disorder, select all that apply:

- Generalized Anxiety
- Obsessive-compulsive disorder
- Agoraphobia
- Panic Disorder
- Post-traumatic stress disorder

7) For either depression or anxiety: Do you have a history of any of the following associated conditions?

- Substance Abuse (drugs or alcohol)
- Suicidal thoughts or attempt? (If yes, provide details regarding treatment, i.e., date of hospitalization, length of stay, inpatient or outpatient treatment, voluntary admission or committal?)
- Bipolar disorder
- Personality disorder
- Psychotic disorder (schizophrenia, delusions)

8) Are you in counseling at the present time? If not, have you had counseling in the past? If yes, provide dates, frequency, and outcome: _____

9) Have you ever been hospitalized or seen in the Emergency Room for treatment of depression, anxiety, or any psychiatric illness? If yes, details: _____

10) Name of doctor(s), specialty, and frequency of visits: _____

11) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

12) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

HEPATITIS C

1) Date of Diagnosis: _____

2) Names and dosages of all medications you are taking: _____

3) Has a liver biopsy been recommended? Yes No

4) If "yes," what were the results: _____

5) Was a cause for the Hepatitis C determined? Yes No

6) If "yes", what was the cause: _____

7) Have you ever been told that you had any of the following?

a) Glomerulonephritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	i) Pulmonary Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Cryoglobulinemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	j) Myopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Porphyria Cutanea Tarda	<input type="checkbox"/> Yes <input type="checkbox"/> No	k) Vasculitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	l) Aplastic Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	m) Liver Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Thrombocytopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	n) Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Autoimmune Thyroiditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	o) Liver Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Sjogren's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	p) Cancer of the liver	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "yes" to any of the above, provide full details regarding treatment received and current status of the condition:

8) Have you ever been told that you have achieved a complete recovery from the Hepatitis C or are in remission?

Yes No

9) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

PREGNANCY

1) Expected date of delivery: _____

2) Any history of Fertility treatment? Yes No

3) Is there a possibility of multiple births? Yes No How many? _____

4) Any known problems for you and/or the baby? _____

5) Have you had prior pregnancies? Yes No How many? _____

Was delivery by C-Section or vaginal delivery? _____

Have you had any multiple gestations? _____

6) Any problems with prior pregnancies? _____

Diabetes – either existing or gestational? _____

Herpes or viral warts? _____

Any known familial genetic disease (i.e. Downs syndrome)? _____

Hypertension/pre-eclampsia? _____

Have you delivered any premature babies or babies with low birth weights? Yes No

If yes, how many weeks gestation and/or what was the baby's birth weight? _____

Have you had any pregnancy end in fetal demise? _____

7) Are you getting regular prenatal care? Yes No

8) Have you been tested for Group B Strep (not strep throat)? Yes No

9) Do you currently smoke? Yes No Have you smoked in the past? Yes No

If yes, when did you quit? _____

10) Name of the doctor treating your pregnancy: _____

11) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

12) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

BREAST CANCER

1) Date of diagnosis: _____

2) How was the cancer treated (check all that apply):

- Excisional biopsy only
- Lumpectomy or wide excision
- Mastectomy
- Radiation Therapy
- Chemotherapy
- Hormonal Therapy (i.e., Tamoxifen, Femara, Zoladex, Aromasin, etc.)

3) If mastectomy, has there been reconstruction? Yes No

Is reconstruction planned in the next two years? Yes No

4) What stage was the cancer? (Stage 0, I, II, III, IV) _____

5) Were lymph nodes involved? Yes No How many? _____

6) Date treatment was completed: _____

7) Has there been any evidence of recurrence? Yes No

8) How often do you see your physician(s) for follow-up and or mammograms? _____

9) Date and results of last mammogram: _____

10) Do you smoke cigarettes? Yes No

11) Are you taking any medications currently? _____

12) Name(s) of the doctor(s) treating you for this condition: _____

13) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

14) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

LEUKEMIA

1) Date of diagnosis: _____

2) Type of Leukemia:

- Acute myelogenous (AML) Acute lymphocytic (ALL)
 Chronic myelogenous (ACL) Chronic lymphocytic (CLL)
 Hairy cell

3) If acute:

- a) Was there evidence of disease outside of the blood and bone marrow (such as in the chest, brain or spinal cord)? _____
b) What type of treatment was used?
 Radiation Chemotherapy
 Stem cell transplantation
c) How long have you been in remission? _____
d) Have you had any recurrences? _____
e) Has bone marrow or stem cells been harvested and stored, or has donor matching been done in the event of a future recurrence? _____

4) If Chronic:

- a) Stage (0, I, II, III, IV): _____
b) Treatment (Select all that apply):
 Watchful waiting (if early stage) Radiation
 Chemotherapy Splenectomy (removal of spleen)
 Immunotherapy (also called biologic therapy)

5) If hairy cell:

- a) Type:
 Untreated Progressive
 Refractory
b) Treatment (select all that apply)
 Chemotherapy Splenectomy
 Immunotherapy Stem cell transplant (for refractory only)

6) List all current medications: _____

7) Name(s) of the doctor(s) treating you for this condition: _____

8) How often do you see your physician(s) for lab/treatment/follow-up? _____

9) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

10) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

LYMPHOMA

1) Date of diagnosis: _____

2) Type of lymphoma:

- Hodgkin's
 Non-Hodgkin's
 Low-grade
 Intermediate
 High-grade

3) Stage at time of diagnosis (Stage 0, I, II, III, IV): _____

4) Did you have any of the following at the time of diagnosis:

- "B" symptoms (fever, night sweats, weight loss)
 Large mediastinal (chest) disease (tumor less than 7.5cm)
 Elevated LDL
 More than one site involved with lymph nodes

5) What type of treatment did you receive (check all that apply):

- "Watch and wait" (for low-grade lymphoma)
 Surgery
 Chemotherapy
 Immunotherapy
 Radiation
 Bone marrow or stem cell transplantation

6) Have you had any recurrences? _____

7) Has bone marrow or peripheral stems cells been harvested and stored or has testing been done for donor match in the event of recurrence? _____

8) Are you currently taking any medication? Yes No

If yes, please provide names and dosages: _____

9) Name(s) of the doctor(s) treating you for this condition: _____

10) How often do you see your physician(s) for routine follow-up? _____

What types of testing, scans or lab are done for routine follow-up? _____

11) Do you smoke? Yes No

12) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

13) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

TRANSIENT ISCHEMIC ATTACK (TIA) OR CEREBROVASCULAR ACCIDENT (STROKE)

1) List date(s) of TIA or stroke: _____

2) Were any of the following studies completed? If yes, provide results.

Carotid ultrasound _____

Head CT or MRI _____

Echocardiogram _____

3) Do you have any residual impairments or deficits? _____

4) Have you ever been told that you have any of the following?

Elevated cholesterol

Diabetes

High blood pressure

Coronary artery disease

Stroke

Heart attack

Peripheral vascular disease

5) Has surgery been done on the carotid artery? Yes No

6) Are you currently taking any medications? Yes No

If yes, please provide medication names and dosages. _____

7) Do you currently smoke? Yes No

If no, have you smoked in the past? If yes, when did you quit? _____

8) What was your most recent blood pressure reading? _____

9) Name(s) of your doctor(s), and how often do you see him/her? _____

10) Have you seen any other doctor for any other reason(s) in the past 5 years? Yes No

If yes, please provide dates, reasons, and results: _____

11) Do you have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on your application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Employer: _____

Name of the person being treated: _____

Height: _____ Weight: _____ Any change in weight in the last 12 months? _____ Yes No

Details _____

JUVENILE HEALTH HISTORY

This questionnaire should be used when a child does not meet the standard guidelines according to the Juvenile height and weight chart. If there are other related conditions such as hypertension, diabetes, juvenile rheumatoid arthritis and/or severe respiratory illness, please use the appropriate health history questionnaire(s).

1) Has there been a greater than 15 pound fluctuation in your child's weight in the last 6 months? Yes No

If yes, please explain: _____

2) Does your child display any signs of being a "picky eater" or demonstrate any other abnormal tendencies towards the consumption of food?

3) How would you describe your child's activity level?

Sedentary (little to no exercise?)

Semi Active (30 or more minutes of exercise at least 3 times per week?)

Active (30 or more minutes of exercise greater than 3 times per week?)

5) Does your child participate in any type of extra physical activity such as organized sports? Yes No

If yes, how often per week and what type? _____

6) Does your child participate in any type of weight training program on a regular basis? Yes No

If so, how often? _____

7) Does your child see any physician on a regular basis? Yes No

If so, why? _____

8) Does your child have any medical condition, symptoms, prescription medications, scheduled or unscheduled treatment that has not been listed on their application or discussed during this conversation? If yes, what? _____

Spoke With: _____

Name of Interviewer: _____ Date: _____

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