HEALTH AND PERSONAL INFORMATION QUESTIONNAIRE

Date _____

_____ _____ _____
First Name Middle Initial Last Name

Name of your personal physician _____

Address of your personal physician _____

_____
City State Zip

Personal physicians phone number _____

Date and reason last consulted _____

What treatment or medication was given or recommended? _____

_____

Height _____ feet _____ inches

Weight _____ lbs.

Weight change in past year ◯ Gain ◯ Loss _____lbs. OR ◯ No change

Reason for change _____

*** Please provide details on Page 3 and 4 for any "Yes" answers to the following Questions ***

	Yes	No
1. Have you ever had or been treated for cancer, leukemia, cyst, polyp, growth or tumor? ……..	◯	◯
2. In the past 10 years, have you had, been told you had, been diagnosed as having , been treated for, seen by a medical practitioner for, or received a consultation or counseling for:		
a. High blood pressure, chest pain or disorder of the heart or circulatory system? ……..	◯	◯
b. Diabetes or disorder of the glands, bone, blood or skin? …….	◯	◯
c. Complications of pregnancy, infertility, or any disorder of the breasts, menstrual cycle, reproductive or genital organs, prostate, kidneys, or urinary systems? …..……..	◯	◯
d. Hernia, hepatitis, acid reflux, recurrent indigestion, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum? ……..	◯	◯
e. Arthritis, rheumatism, or disorder of the joints, limbs or muscles? …….	◯	◯
f. Disorder or condition of the back, neck or spine? ……	◯	◯

	Yes	No
g. Allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? ……..	○	○
h. Epilepsy, stroke, dizziness, headache, paralysis, or disorder of the brain and/or spinal cord? ……..	○	○
i. Disorder of the eyes, ears, nose or throat? ……	○	○
j. Anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? ……	○	○
k. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr virus or Lyme disease?.....	○	○
l. Miscarriage, C-section or complication of pregnancy?.....	○	○
3. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? ……	○	○
4. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ……	○	○
5. Do you now take, or in the last 3 years have you taken, any prescription medicine?……	○	○
6. Do you now take, or in the last 3 years have you taken, any <u>non</u>-prescription medicine or natural or herbal supplement?…….....…	○	○
7. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance? …	○	○
8. Have you ever had or been advised to have counseling or treatment for alcohol or drug use? ..	○	○
9. Are you now pregnant? If yes, expected delivery date: _____ ……..	○	○
10. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim? ……..	○	○
11. Within the past five years, have you had a physical exam or check-up of any kind) excluding an AIDS test)? ……..	○	○
12. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests? ……..	○	○
13. Within the past 3 years, have you had symptoms of any condition listed in these questions **for which you have not sought medical attention or advice?** (Except those conditions listed in question number 4). ……..	○	○
14. Other than as previously stated on this application, in the last five years have you received medical advice or counseling from physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, or other practitioners, or have you been a patient in a hospital, clinic, sanatorium, or other medical facility? ……..	○	○

15. Do you have a family history of: diabetes, cancer, high blood pressure, heart disease, mental illness or suicide? ……..

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			
No. Living _____			
No. Dead _____			

DETAILS OF "YES" ANSWERS. IDENTIFY QUESTION AND NUMBER.

Give diagnosis of symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, practitioners or hospitals. Additional paper may be attached if necessary to explain details.

_____

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NEXT PAGE CAN ALSO BE USED FOR DETAILS

DETAILS