

## MercyOne Application Checklist

Please follow the below checklist to ensure your application is complete and to avoid unnecessary underwriting delays.

- Complete the General Member Information section (page 1). Include the name, gender, height, weight, social security number, and date of birth for every person applying for coverage.
- You may only request an effective date of the 1<sup>st</sup> of the month (page 2).
- Select the plan option for which you will be applying (page 2).
- Answer all Health History questions (pages 3, 4, and 5). Also, list all prescriptions and over the counter medications taken for each person applying for coverage. Failure to answer these questions will delay the underwriting of your application.
- If you answered “yes” to questions on page 5, please give complete details in the attached Secondary Questions section. Refer to the page number listed next to the condition on where to answer.
- List the primary care physician, phone number, and date of last visit for each person applying for coverage (page 4).
- Statements of Understanding (page 6): The primary Applicant and Spouse must initial and date this page.
- Authorization to Use and Disclose Protected Health Information (page 7): Each enrolling Applicant age 18 or over will need to sign and date this page. **If your application is dated more than 60 days from the requested effective date, you will be asked to re-apply.**
- Complete the selected method of payment (page 8). Payment for this policy can be made by automatic withdrawal from a checking or savings account. Mercy Health Plans may also draft from a Visa or MasterCard (plus a 2% administration fee). All payment options are withdrawn on a monthly basis on or about the 15<sup>th</sup> of the month.
- Secondary Questions (pages 9–15): Provide details for all conditions for each person applying for coverage. The primary Applicant and Spouse must initial and date each page of the Secondary Questions ensuring that all medical information is disclosed.

If you need assistance in completing your application, please contact your agent. If you do not have an agent, please contact the MercyOne sales department at 314-214-8050 or 800-315-8682.



Mercy Health Plans  
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 Chesterfield, MO 63017-5743  
 314-214-8050 • 1-800-315-8682

# Application for Individual Comprehensive Health Insurance



**Please complete in black only.**

**Application Type:**

**Coverage Information (Select One):**

New Coverage                     
  Change MercyOne policy coverage                     
  Add dependent (s) to current coverage  
 Member No. \_\_\_\_\_                     
 Member No. \_\_\_\_\_

**Applicant Information**

Please enter the following applicant information: (If applying for Child Only Coverage, record the child's information in the following section. Please submit a separate application for each Child Only Applicant.)

<b>NAME:</b>	First	Middle	Last	<b>Subscriber's Occupation:</b>
<b>HOME ADDRESS:</b>	Street & P.O. Box if applicable		City	State    Zip                      County
<b>Home Phone #:</b> (____) _____	Best time to call: <input type="checkbox"/> Day <input type="checkbox"/> Evening		<b>E-mail (this will not be shared with a 3rd party):</b>	
<b>Work/Cell Phone #:</b> (____) _____				

**General Member Information:** Please complete information below for all family members applying for coverage (attach other pages, if needed).

Name			Relationship to Applicant	Sex M/F	Height		Weight lbs.	SSN#	Date of Birth (mm/dd/yyyy)
First	MI	Last			Ft.	In.			
			Self						
			Spouse						
			Child						
			Child						
			Child						
			Child						
			Child						
			Child						

**Producer Information:** If you have a Producer (Broker or Agent) that will be assigned to your account, HAVE HIM/HER COMPLETE THIS SECTION.

**Note:** Mercy Health Plans (MHP) may share medical information with the Producer concerning you or your covered dependents that is contained in this application or discovered in the course of processing the application. The writing (and any assisting) Producer's current Missouri health insurance license must be on file with MHP prior to acceptance of this application.

Do you know of any significant medical information relating to the applicant or any of his dependents that has not been reported on this form? Yes  No

For purposes of processing commission, please provide the following information\*:

Agency Name: \_\_\_\_\_ Broker's Name: \_\_\_\_\_

Broker's Telephone # \_\_\_\_\_ Broker's Email: \_\_\_\_\_

Broker's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notification: Broker Only  (Broker to receive policy)  
 Broker and Subscriber  (Member to receive policy, Broker to receive copy by email)

\* Please fill out this information as it appears on your W-9 form.

**Coverage and Benefit Selection:** To choose the type of coverage that you would like, select ONE option from EACH of the sections numbered 1, 2, 3 and 4 below.

- 1) Type of coverage:  Applicant only (Ages 19-65 yrs.)  Child Only (Age 6 mos. – 18 yrs.)  Applicant & spouse  
 Applicant & unmarried children\*  Applicant, spouse & unmarried children\*  
 \* Unmarried dependent children up to age 25.
- 2) Effective date requested: \_\_\_/\_\_\_/\_\_\_ 1<sup>st</sup> of the month only  
*Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.*
- 3) OPTIONAL RIDERS: Family Services Rider (tubal ligations & vasectomies) – Additional \$4.50 /month (per application)  
 (Applies only to subscriber and enrolled spouse)  YES  NO
- 4) **Traditional Plan Option:** Choose ONLY ONE Plan option.  
*Note: Maternity benefits apply only to the applicant or applicant's spouse, and will not begin for one year.*

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
<input type="checkbox"/> A-09	12 month	No	\$1,000	\$2,000	\$20/\$40	100/70%	\$10/\$40/\$65
<input type="checkbox"/> B-09	12 month	No	\$2,500	\$5000	\$20/\$40	100/70%	\$10/\$40/\$65
<input type="checkbox"/> AA-09	12 month	Yes	\$1,000	\$2,000	\$20/\$40	100/70%	\$10/\$40/\$65
<input type="checkbox"/> BB-09	12 month	Yes	\$2,500	\$5000	\$20/\$40	100/70%	\$10/\$40/\$65
<input type="checkbox"/> D-09	12 month	No	\$500	\$1,000	\$20/\$40	80/60%	\$10/\$40/\$65
<input type="checkbox"/> E-09	12 month	No	\$1,000	\$2,000	\$20/\$40	80/60%	\$10/\$40/\$65
<input type="checkbox"/> F-09	12 month	No	\$2,500	\$5,000	\$20/\$40	80/60%	\$10/\$40/\$65
<input type="checkbox"/> DD-09	12 month	Yes	\$500	\$1,000	\$20/\$40	80/60%	\$10/\$40/\$65
<input type="checkbox"/> EE-09	12 month	Yes	\$1,000	\$2,000	\$20/\$40	80/60%	\$10/\$40/\$65
<input type="checkbox"/> FF-09	12 month	Yes	\$2,500	\$5,000	\$20/\$40	80/60%	\$10/\$40/\$65

**HDHP/HSA Plan**

*Note: Maternity benefits apply only to the applicant or applicant's spouse, and will not begin for one year.*

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
<input type="checkbox"/> 1500B -09	12 month	No	\$1,500	\$3,000	80/60%	80/60%	\$10/\$40/\$65
<input type="checkbox"/> 3000A-09	12 month	No	\$3,000	\$6,000	100/75%	100/75%	100%
<input type="checkbox"/> 5000A-09	12 month	No	\$5,000	\$10,000	100/75%	100/75%	100%
<input type="checkbox"/> 1500BB -09	12 month	Yes	\$1,500	\$3,000	80/60%	80/60%	\$10/\$40/\$65
<input type="checkbox"/> 3000AA-09	12 month	Yes	\$3,000	\$6,000	100/75%	100/75%	100%
<input type="checkbox"/> 5000AA-09	12 month	Yes	\$5,000	\$10,000	100/75%	100/75%	100%

- Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please forward my information to Mercy Health Plans' banking partner, Bank of America.
- No, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please DO NOT forward my information to Mercy Health Plans' banking partner, Bank of America.

Other Health Coverage:	Yes	No
1) Are you or anyone that is applying for coverage currently eligible for Medicare? If “yes”, please list name(s):	<input type="checkbox"/>	<input type="checkbox"/>
2) Have you ever had your coverage through Mercy Health Plans terminated for failure to pay premiums? If your coverage was terminated by Mercy Health Plans for non-payment of premiums, you must wait 12 months before applying for coverage and one month’s advance premium may be required.	<input type="checkbox"/>	<input type="checkbox"/>
3) Did you and/or your spouse and/or your eligible dependents have creditable coverage within the past 63 days or more? If “yes”, you may be eligible for pre-existing credit. If applicable, submit a copy of the Certificate of Creditable Coverage for each person applying and complete the questions below: <b>Names of Covered Persons: (If the entire family, write ALL in the space below)</b> _____ _____ _____ _____  <b>Name &amp; Phone Number of Prior Carrier(s):</b> _____ _____  <b>Effective Date of Coverage:</b> _____ <b>Cancellation Date of Coverage:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
Health History: Complete your health history by answering “Yes” or “No” to the questions in the following section.	Yes	No
1) Have you or any family member(s) who are applying for coverage smoked or used other smokeless tobacco products within the last 12 months? If “yes”, list name(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
2) Is any proposed insured currently pregnant, an expectant parent, or in the process of adoption or surrogate pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you or any family member(s) who are applying for coverage have any health conditions that a reasonably prudent person would anticipate requiring future medical treatment or surgery within the next 12 months? If so, what are those health conditions, and what treatments are considered? (Attach other pages if needed) _____ _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
4) In the last ten years have you or any family member(s) applying for coverage had any symptoms, diagnoses or treatments of any disease, disorder or injury, or had any test results that were abnormal? If so, what are those disease states, injuries or abnormal test results? (Attach other pages if needed) _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>



<b>Health History (continued):</b> Complete your health history by answering “Yes” or “No” to the questions in the following section.	<b>Yes</b>	<b>No</b>
7) Have you or any family member(s) applying for coverage currently have, or have ever been diagnosed or treated for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases?	<input type="checkbox"/>	<input type="checkbox"/>

**Check “Yes” or “No” for all conditions listed below as they apply for any covered family member.**

**NOTE:** If you answer “Yes” to any of these screening questions, **you must also answer the *Secondary Questions*** related to those conditions attached to this form. Refer to the page number listed in the *Secondary Questions to the Application for Individual Health insurance*.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes, pg 9	<input type="checkbox"/>	<input type="checkbox"/>	11. Epilepsy/Seizure Disorder, pg13
<input type="checkbox"/>	<input type="checkbox"/>	2. Endocrine/Thyroid/Pituitary/Adrenal, pg 9	<input type="checkbox"/>	<input type="checkbox"/>	12. Mental or Psychiatric Condition/Depression/Behavioral or Eating Disorder, pg 13
<input type="checkbox"/>	<input type="checkbox"/>	3. High Blood Pressure/Hypertension, pg 9	<input type="checkbox"/>	<input type="checkbox"/>	13. Drug or Alcohol Abuse, pg 14
<input type="checkbox"/>	<input type="checkbox"/>	4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol, pgs 10	<input type="checkbox"/>	<input type="checkbox"/>	14. Back or Neck Disorder, pg 14
<input type="checkbox"/>	<input type="checkbox"/>	5. Respiratory/Lung/Asthma/TB/COPD, pgs 10 & 11	<input type="checkbox"/>	<input type="checkbox"/>	15. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder, pgs 14 & 15
<input type="checkbox"/>	<input type="checkbox"/>	6. Ears/Eyes/Nose/Throat/Skin Disorder, pg 11	<input type="checkbox"/>	<input type="checkbox"/>	16. Muscular Disorder/Lupus, pg 15
<input type="checkbox"/>	<input type="checkbox"/>	7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's, Polyps, Hepatitis, pgs 11 & 12	<input type="checkbox"/>	<input type="checkbox"/>	17. Cancers/Tumors/Cysts, pg 15
<input type="checkbox"/>	<input type="checkbox"/>	8. Prostate/Reproductive Organ Disorder/Infertility/STD, pg 12	<input type="checkbox"/>	<input type="checkbox"/>	18. HIV/AIDS/ARC/Auto-Immune Disorder, pg 15
<input type="checkbox"/>	<input type="checkbox"/>	9. Urinary Tract/Kidney or Renal Disease, pg 12	<input type="checkbox"/>	<input type="checkbox"/>	19. Any Other Illness, Disease or Injury, pg 15
<input type="checkbox"/>	<input type="checkbox"/>	10. Nervous System/Brain Disorder/Headache, pg 13			

**Statements of Understanding:**

Please read all statements below.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans (MHP).
2. I understand that I will receive either an acceptance or denial from MHP or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application.
3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full. If my coverage is terminated, I will be unable to reapply for an Individual policy with Mercy Health Plans for one year.
4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.
5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical condition disclosed within this application will not be covered for up to 12 months after my effective date. (Credit may be given for prior creditable coverage upon receipt of certificate of creditable coverage.)
6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage may be rescinded in its entirety at MHP's discretion.
7. I understand that I, or any of my covered family members, may need to obtain a physical examination at my own expense and submit the results as part of my application for coverage, if such an examination has not been performed within the last two years.
8. I understand that I, or any of my covered family members, must notify Mercy Health Plans if we seek and receive medical attention from the time this application is completed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change.
9. I understand that if I purchase maternity benefits, they apply only to my spouse or me and do not begin until we have been covered for 12 months under the plan that includes the maternity benefit. Maternity benefits are not available for our dependent children and do not apply to child only plans.
10. I understand and agree that Mercy Health Plans may obtain or request information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.
11. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.

**Primary Applicant's initials:** \_\_\_\_\_ **Spouse's initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorization to Use and Disclose Protected Health Information**

**NOTE: It is required that this Authorization to Use and Disclose Protected Health Information be completed and submitted with the application. The application is not complete without this authorization form.**

**Each person age 18 or over who is to be covered by this policy must sign at the bottom of this form.**

I authorize Mercy Health Plans (MHP) or its affiliates to obtain necessary individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports from physicians, hospitals or other health care providers pertaining to my care or the care of any other dependent(s) listed on the application for insurance. I understand that this information can be used to determine my/our eligibility for insurance, and that those records can be requested as far back as the past ten years.

I authorize MHP to share necessary information with my Producer (Broker or Agent). I understand that Mercy Health Plans may disclose individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports to other entities in the course of its business operations or as required or permitted by law or as set out in the Mercy Health Plans Notice of Privacy Practices and authorize such disclosure. I also understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

This authorization is valid for the duration of my coverage with Mercy Health Plans. I understand that this authorization is voluntary and that I may revoke this authorization at any time; however, if I do so before I am enrolled in the policy(ies), my application for coverage may be denied. A revocation request must be sent to MHP in writing to our home address, or via e-mail. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

All listed applicants 18 years of age and older must agree to the terms of this authorization. Signing this document confirms agreement. I understand and agree to the release of information for the purpose described above in this document.

**By signing, I agree that I have fully read this entire application, and I understand and agree with all statements contained herein:**

	<b>Signature Required:</b>	<b>Printed Name:</b>	<b>Date:</b>
Applicant			
Applicant's Spouse			
Dependent 18 yrs. or older			
Dependent 18 yrs. or older			
Dependent 18 yrs. or older			

**If your application is dated more than 60 days beyond the requested effective date for coverage, a new application must be completed.**

**Note: Coverage will not begin until all necessary information is received by MHP. MHP will notify you of the approved effective date.**

**Payment Information:**

Applicant Name \_\_\_\_\_

All premium payments are made **either** via debit ACH (automatic withdrawal) from your bank or by credit card\*.

Please check your method of payment:

**Automatic Bank Account Withdrawal**

- Checking account (attach voided check below)
- Savings Account

Account # \_\_\_\_\_

Routing # \_\_\_\_\_

**Credit Card**

- VISA       MasterCard

**Cardholder's Name (as it appears on the card):**

\_\_\_\_\_

**Billing Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone** \_\_\_\_\_

**Credit Card Number:** \_\_\_\_\_

**Expiration Date (month/year):** \_\_\_\_ / \_\_\_\_

**3-Digit Verification Code:** \_\_\_\_\_ (See signature area on back of card)

**I authorize Mercy Health Plans to charge my credit card on the 15th of each month for the amount of my monthly premium plus a 2% administrative fee.**

**I authorize a one-time charge to my credit card for \$ \_\_\_\_\_ premium plus a 2% administration fee.**

\_\_\_\_\_  
**Signature of Cardholder**

\_\_\_\_\_  
**Date**

\* Note: You may be charged an additional fee for insufficient funds or incorrect banking information

.....

**Attach Voided Check Here**



	YES	NO
<b>4. Heart/Circ/Stroke/Aneurysm/Cholesterol</b>	<input type="checkbox"/>	<input type="checkbox"/>
Which family member(s) has a heart/circulatory system condition?		
<hr/>		
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Which type of aneurysm?		
<input type="checkbox"/> Abdominal/Descending Thoracic Aortic		
<input type="checkbox"/> Brain <input type="checkbox"/> Femoral/Peripheral <input type="checkbox"/> Other type		
Has aneurysm been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, when was surgery (in MMYYYY)	____/____/____	
If NO, any further problems?	<input type="checkbox"/>	<input type="checkbox"/>
Hypercholesterolemia/Hyperlipidemia/High blood lipids/		
High blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
What are cholesterol levels (in mg/dl)?		
<input type="checkbox"/> <=220 <input type="checkbox"/> >220<=250 <input type="checkbox"/> >250<=300 <input type="checkbox"/> >300		
Are above levels while on cholesterol meds?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
What type of anemia do you have:		
<input type="checkbox"/> Unknown/Other <input type="checkbox"/> Thalassemia Major		
<input type="checkbox"/> Pernicious <input type="checkbox"/> Iron Deficiency		
<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Hemolytic Anemia		
If hemolytic, have you had a splenectomy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, when was surgery (in MMYYYY)?	____/____/____	
Bleeding disorders/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease/Heart Attack/		
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Have you had? <input type="checkbox"/> Angioplasty <input type="checkbox"/> Cardiac Bypass Surg		
<input type="checkbox"/> Neither Angioplasty nor Bypass Surgery		
If performed, date procedure done?	____/____/____	
If history of heart attack, give date:	____/____/____	
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Is the only treatment drug therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any hospitalizations for?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomegaly/Enlarged heart	<input type="checkbox"/>	<input type="checkbox"/>
Are you a heart transplant candidate?	<input type="checkbox"/>	<input type="checkbox"/>
Is the reason for the enlargement known?	<input type="checkbox"/>	<input type="checkbox"/>
If known, describe: _____		
<hr/>		
Do you have any impairment from condition?	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular Disease/Claudication	<input type="checkbox"/>	<input type="checkbox"/>
Is diagnosis? <input type="checkbox"/> Reynaud's Disease <input type="checkbox"/> Buerger's Disease		
<input type="checkbox"/> Neither Reynaud's or Buerger's		
Cerebral Vascular Accident (CVA)/Stroke/	<input type="checkbox"/>	<input type="checkbox"/>
Transient Ischemic Attack (TIA)		
Was diagnosis CVA or TIA? <input type="checkbox"/> CVA <input type="checkbox"/> TIA		
Date symptoms began:	____/____/____	
Any residual impairment?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Arrhythmias/Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
Episodes are: <input type="checkbox"/> Single <input type="checkbox"/> Multiple <input type="checkbox"/> Chronic		
If multiple, are they controlled?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, are they controlled: <input type="checkbox"/> Drugs <input type="checkbox"/> Surgical device		
Conduction disturbances/Bundle Branch Blocks	<input type="checkbox"/>	<input type="checkbox"/>
Cause known for conduction disturbances?	<input type="checkbox"/>	<input type="checkbox"/>
If cause known, describe: _____		
<hr/>		
Cardiac implantable device/pacemaker installed?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery?	____/____/____	
Chest pain/Angina/Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Is clinical work up suggestive of coronary artery disease/blocked cardiac arteries?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date of symptoms onset (in MMYYYY)?	____/____/____	
Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently have one of these conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had: <input type="checkbox"/> Single episode <input type="checkbox"/> Multiple episodes		
If single episode, date of onset of symptoms?	____/____/____	
If multiple, date recovered from last episode?	____/____/____	
Are you on anti-clotting RX?	<input type="checkbox"/>	<input type="checkbox"/>
Edema/Swelling of the extremities	<input type="checkbox"/>	<input type="checkbox"/>
Do you know what is causing swelling	<input type="checkbox"/>	<input type="checkbox"/>
If YES, describe: _____		
<hr/>		
Cardiac Valve disorders/Heart Murmur/Mitral Valve Prolapse/		
Mitral Regurgitation/Mitral Stenosis	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, was the valve: <input type="checkbox"/> Repaired <input type="checkbox"/> Replaced		
If YES, date of surgery:	____/____/____	
If NO, is the patient symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Artery Occlusion	<input type="checkbox"/>	<input type="checkbox"/>
Is disease symptomatic and documented?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had surgery to correct?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
Are you on the waiting list for heart transplant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you know what is causing cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, describe: _____		
<hr/>		
Pericarditis	<input type="checkbox"/>	<input type="checkbox"/>
Is diagnosis restrictive pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, did the patient have surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If surgery, give date of surgery:	____/____/____	
Other disease of the heart or circulatory system	<input type="checkbox"/>	<input type="checkbox"/>
Please describe condition: _____		

	YES	NO
<b>5. Respiratory/Lung Disorder/Asthma/TB</b>	<input type="checkbox"/>	<input type="checkbox"/>
Which family member(s) has a respiratory system condition?		
<hr/>		
Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have:		
<input type="checkbox"/> Allergies Only <input type="checkbox"/> Asthma & Allergies		
<input type="checkbox"/> Allergies Only <input type="checkbox"/> Asthma Only		
If allergies, are you on desensitization shots?	<input type="checkbox"/>	<input type="checkbox"/>
If asthma, are attacks occasional or frequent?		
<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent		

	YES	NO
Pulmonary Embolism/Pulmonary Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Is it known what caused embolism/infarction?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe condition: _____		
<hr/>		
Single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient continuing anticoagulant drug treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient fully recovered?	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea/Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>

Primary Applicant's Initials: \_\_\_\_\_ Spouse's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

	YES	NO		YES	NO
<b>5. Respiratory/Lung Disorder/Asthma/TB, contd.</b>					
If asthma, any hospitalizations for?	<input type="checkbox"/>	<input type="checkbox"/>	Known underlying condition causing this?	<input type="checkbox"/>	<input type="checkbox"/>
If asthma, nebulizer used for acute episodes?	<input type="checkbox"/>	<input type="checkbox"/>	Please describe underlying condition: _____		
If asthma, are you taking corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Is asthma under control with medications?	<input type="checkbox"/>	<input type="checkbox"/>	How would you characterize symptoms?		
Is the shortness of breath exercise induced?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Are you a recipient or candidate for a transplant?	<input type="checkbox"/>	<input type="checkbox"/>
In last two years number of hospitalizations for bronchitis?			Other respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> not at all <input type="checkbox"/> one time <input type="checkbox"/> > than once			Please describe other condition: _____		
Chronic Obstructive Lung Disease (COPD)/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>			
If YES, do you own a C-Pap machine?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>			
If YES, when was surgery (in MMYYYY):	____/____/____				

	YES	NO		YES	NO
<b>6. Ear/Eye/Nose/Throat/Skin</b>					
Which family member(s) has an EENT or skin condition?	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
_____			Episodes are: <input type="checkbox"/> Mild <input type="checkbox"/> Severe		
Middle ear infections/tubes in ears/Otitis Media	<input type="checkbox"/>	<input type="checkbox"/>	Taking Enbrel/Other Biologic RX injections for?	<input type="checkbox"/>	<input type="checkbox"/>
Are infections chronic?	<input type="checkbox"/>	<input type="checkbox"/>	Cellulitis-skin infection	<input type="checkbox"/>	<input type="checkbox"/>
Has there been more than one infection?	<input type="checkbox"/>	<input type="checkbox"/>	More than one episode?	<input type="checkbox"/>	<input type="checkbox"/>
Are tubes present in ear canals?	<input type="checkbox"/>	<input type="checkbox"/>	Are the episodes severe?	<input type="checkbox"/>	<input type="checkbox"/>
Date of most recent episode (in MMYYYY)?	____/____/____		When was since last episode (in MMYYYY)?	____/____/____	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis/Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Both eyes?	<input type="checkbox"/>	<input type="checkbox"/>	Is condition chronic?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>	How many infections do you have a year?	____/____/____	
If YES, date it was done (in MMYYYY)?	____/____/____		Any hearing impairment or implant?	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Other Ear/Eye/Nose/Throat or Skin condition	<input type="checkbox"/>	<input type="checkbox"/>
If yes, provide current ocular pressure	____/____/____		Please describe: _____		
Tonsillitis			_____		
Has the patient had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>			
Single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>			
Date of last episode of symptoms (in MMYYYY)?	____/____/____				

	YES	NO		YES	NO
<b>7. Digestive/Intestinal/Liver Disorder</b>					
Which family member(s) has a digestive system condition?	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
_____			Inguinal, Scrotal or Femoral hernia?	<input type="checkbox"/>	<input type="checkbox"/>
GERD/Gastroesophageal Reflux Disease/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Has it been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
Did symptoms abate/improve with drug therapy?	<input type="checkbox"/>	<input type="checkbox"/>	If no, any symptoms from?	<input type="checkbox"/>	<input type="checkbox"/>
Are drugs you're taking prescribed by physician?	<input type="checkbox"/>	<input type="checkbox"/>	If unoperated and symptomatic, are symptoms managed		
Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	by medicine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease/Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Currently under treatment		
Have you had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Single Attack in the past		
If YES, what kind of surgery was done?			<input type="checkbox"/> Multiple Attacks in the past		
<input type="checkbox"/> Partial bowel resection <input type="checkbox"/> Total bowel resection			If multiple date of last episode of symptoms:	____/____/____	
Gastrointestinal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
When was last bleeding episode (in MMYYYY)?	____/____/____		Is condition chronic or acute?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently under treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Any history of alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis/Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Any subsequent liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently have symptoms from this?	<input type="checkbox"/>	<input type="checkbox"/>	Single episode of pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient currently have?	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis of the Liver/Hepatitis/Liver Disease			If NO, date of last episode of symptoms:	____/____/____	

Primary Applicant's Initials: \_\_\_\_\_ Spouse's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

	YES	NO		YES	NO
<b>7. Digestive/Intestinal/Liver Disorder, contd.</b>					
Which type of liver disease has been diagnosed?	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis/Chronic Inflammation of Colon	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cirrhosis			Single or multiple episodes?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hepatitis A			Have you had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hepatitis B			If YES, date surgery done (in MMYYYY)?	____/____/____	
<input type="checkbox"/> Hepatitis C			If YES, is patient on prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alcoholic Hepatitis			If NO, is condition under control?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic Hepatitis			If NO, is patient taking steroid medication?	<input type="checkbox"/>	<input type="checkbox"/>
If Hepatitis A, B or C - Normal liver function tests?	<input type="checkbox"/>	<input type="checkbox"/>	If NO, date last episode of symptoms:	____/____/____	
If Hepatitis C - Taking Interferon by injection?	<input type="checkbox"/>	<input type="checkbox"/>	Other digestive/intestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Disease/Cholelithiasis/Cholecystitis	<input type="checkbox"/>	<input type="checkbox"/>	Please describe: _____	_____	
Was it a single attack of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	
Has the gall bladder been removed?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	
If YES, date surgery done?	____/____/____				
If No, date of last attack of symptoms?	____/____/____				
Colon Polyps/Rectal Polyps	<input type="checkbox"/>	<input type="checkbox"/>			
Benign?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
<b>8. Reproductive Disorder/Prostate/STD</b>					
Which family member(s) has a reproductive system condition?	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>
_____			Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids/Dysfunctional Uterine Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Are the cysts benign?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>	Any symptoms from condition?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, when was surgery (in MMYYYY)?	____/____/____		Cervical Dysplasia/Abnormal Pap Smears	<input type="checkbox"/>	<input type="checkbox"/>
Was there a malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	More than one abnormal Pap in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Benign Prostatic Hypertrophy/Prostatic Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Prolapsed Uterus	<input type="checkbox"/>	<input type="checkbox"/>
Is there a malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery to correct?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had prostate surgery?	<input type="checkbox"/>	<input type="checkbox"/>	If you had surgery, give date:	____/____/____	
Any symptoms related to prostatic enlargement?	<input type="checkbox"/>	<input type="checkbox"/>	Other disorder of the reproductive system	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	Please describe condition: _____	_____	
Which type?			_____	_____	
<input type="checkbox"/> Genital Herpes--date of last episode:	____/____/____				
<input type="checkbox"/> Chlamydia - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Gonorrhea - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Syphilis - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Venereal Warts - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
<b>9. Urinary Tract/Kidney or Renal Disease</b>					
Which family member(s) has a kidney or urinary tract condition?	<input type="checkbox"/>	<input type="checkbox"/>	If NO, date of last episode:	____/____/____	
_____			More than two episodes of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Cystitis/Urinary Tract Infection (UTI)/Pyuria/Urethritis	<input type="checkbox"/>	<input type="checkbox"/>	Were stones in one or both kidneys?		
Single episode?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Unilateral/One kidney only		
When was last episode (in MMYYYY)?	____/____/____		<input type="checkbox"/> Bilateral/Both kidney		
Was there any protein/discharge/blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	Interstitial cystitis	<input type="checkbox"/>	<input type="checkbox"/>
Cystic disease of kidneys	<input type="checkbox"/>	<input type="checkbox"/>	Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Solitary Cyst			If NO, date of last episode:	____/____/____	
<input type="checkbox"/> Polycystic			Acute Renal failure/Chronic Renal failure	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery (in MMYYYY)?	____/____/____		If NO, date of recovery:	____/____/____	
History of kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>	Other Kidney/Urinary tract disorder	<input type="checkbox"/>	<input type="checkbox"/>
When was surgery (in MMYYYY)?	____/____/____		Please describe condition: _____	_____	
Any post-surgical complications?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	
Renal calculi/Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>			
Currently have?	<input type="checkbox"/>	<input type="checkbox"/>			

Primary Applicant's Initials: \_\_\_\_\_ Spouse's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**10. Nervous System/Brain Disorder/Headache**  YES  NO

Which family member(s) has a nervous system condition?  
\_\_\_\_\_

Headaches/Migraines/Cluster Headaches  YES  NO

Characterization of severity & frequency of headaches (pick one)  
 Mild, less than 5/year     Severe, > 10/year  
 Moderate-5 - 10/year     Recent onset of severe HA

Multiple Sclerosis  YES  NO  
 Recently diagnosed?  YES  NO

Head Injury/Concussion  YES  NO  
 Was there a loss of consciousness?  YES  NO  
 If YES, how long was loss of consciousness?  
 < 1 hour     < 1 day     more than 1 day  
 If < 1 hour-Any residual problems post recovery?  YES  NO  
 If < 1 day – give date of recovery: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 If < 1 day-Any residual problems post recovery?  YES  NO

Encephalitis/Encephalomyelitis  YES  NO  
 Currently have?  YES  NO  
 If NO, any residual complications post recovery?  YES  NO  
 If NO, how long since recovery (in MMYYYY)? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Heat Exhaustion/Heat Stroke  YES  NO  
 Which diagnosis?  Heat Exhaustion     Heat Stroke  
 Single episode?  YES  NO  
 If NO, date of last episode: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**YES** **NO**

Neuroma/Abnormal Nerve Growth  YES  NO  
 Is growth benign?  YES  NO  
 Has the patient been operated on?  YES  NO  
 If YES, when was surgery (in MMYYYY)? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 If NO, when was recovery (in MMYYYY)? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Is the diagnosis Morton's Neuroma?  YES  NO

ALS/Amyotrophic Lateral Sclerosis/  
 Lou Gehrig's Disease  YES  NO

Autism  YES  NO  
 Cerebral Palsy  YES  NO  
 Paralysis/Hemiplegia/Paraplegia  YES  NO  
 Parkinson's Disease  YES  NO  
 Spina Bifida  YES  NO  
 Viral Meningitis  YES  NO  
 Bacterial Meningitis  YES  NO  
 Muscular Dystrophy  YES  NO  
 Motor Neuron Disease  YES  NO  
 Neuralgia/Neuritis  YES  NO  
 Dementia  YES  NO  
 Other disorder of the nervous system  YES  NO  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**11. Epilepsy/Seizure Disorder**  YES  NO

Which family member(s) has epilepsy or seizure disorder?  
\_\_\_\_\_

Seizure Disorder  YES  NO  
 Do you know what type of seizure has been diagnosed?  
 If YES, what is seizure type?  Febrile  
 Petit Mal     Jacksonian  
 Grand Mal     Focal

Is another disease condition causing seizures?  YES  NO  
 If YES, please describe condition: \_\_\_\_\_  
 \_\_\_\_\_

**YES** **NO**

Are seizures increasing in frequency?  YES  NO  
 Is patient taking medications?  YES  NO  
 If YES, are seizures controlled by medication?  YES  NO  
 When was the last seizure (in MMYYYY)? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Other seizure disorder  YES  NO  
 Please describe condition: \_\_\_\_\_  
 \_\_\_\_\_

**12. Mental/Psychiatric Condition/Depression**  YES  NO

Which family member(s) has a mental health condition?  
\_\_\_\_\_

Affective Disorders  YES  NO  
 What is diagnosis (pick one below)?  
 Obsessive Compulsive Disorder (OCD)  
 Panic Disorder     Agoraphobia  
 Anxiety Disorder     Neuroses

Is treatment effective?  YES  NO  
 If YES, date treatment become effective? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 What is characterization of severity of symptoms?  
 Mild     Moderate     Severe

Schizophrenia/Paranoia  YES  NO

**YES** **NO**

Major Depression/Bipolar Disorder  YES  NO  
 When was diagnosis made (in MMYYYY)? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Eating Disorder/Bulimia/Anorexia  YES  NO  
 Do you currently have an eating disorder?  YES  NO  
 When was recovery (in MMYYYY)? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Attention Deficit Disorder/ADD/ADHD  YES  NO  
 What is characterization of severity of symptoms?  
 Mild     Moderate     Severe  
 Are symptoms controlled by medication?  YES  NO  
 Situational Depression/Mild Depression/Anxiety  YES  NO  
 Is only current treatment prescription medication?  YES  NO  
 Other mental health/psychiatric disorder  YES  NO  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_

Primary Applicant's Initials: \_\_\_\_\_ Spouse's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

	YES	NO		YES	NO
<b>13. Drug or Alcohol Abuse</b>	<input type="checkbox"/>	<input type="checkbox"/>			
Which family member(s) has history of drugs or alcohol abuse? _____					
What is patient dependent on?			Is the patient currently using?		
<input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Drugs besides marijuana and alcohol			<input type="checkbox"/> <input type="checkbox"/> If not currently using, when did the patient last use drugs/alcohol (in MMYYYY)?      ____/____		

	YES	NO		YES	NO
<b>14. Back or Neck Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>			
Which family member(s) has a back or neck condition? _____					
Cervical (Neck) or Thoracic (Mid Back) or Lumbar (Low Back)					
Disc Herniation or Protrusion					
Are you under current treatment for?			Ankylosing Spondylitis/Spondylolisthesis		
Have you had surgery for condition?			Have you had surgery for condition?		
If YES, any subsequent problems post-op?			If NO, is condition symptomatic, requiring treatment?		
If YES, date of surgery (in MMYYYY)?			Sciatica/Radiculitis/Radiating pain to legs or arms		
If no surgery was done, have you recovered?			Does patient have any neurological defects?		
If you have recovered, date of recovery?			Is patient currently under treatment for?		
_____ / _____			Are episodes recurrent?		
_____ / _____			When was last episode (in MMYYYY)?		
_____ / _____			_____ / _____		
Low Back Pain					
Are you under current treatment for?			Spinal deformities/Scoliosis/Lordosis		
If not in current treatment, date of last episode? ____/____			Has patient had surgery for condition?		
_____ / _____			If surgery, any continuing problems post-op?		
_____ / _____			If surgery was done, date of surgery?		
_____ / _____			If no surgery, are you currently under treatment?		
_____ / _____			If you are currently under treatment, is condition?		
_____ / _____			<input type="checkbox"/> Mild or moderate <input type="checkbox"/> Severe		
_____ / _____			If no current treatment, date of last treatment? ____/____		
Spinal Fractures					
Any lingering neurological defects?			Spina Bifida/Myelocoele		
Was fracture a compression fracture?			Has patient had surgery for condition?		
When was last treatment (in MMYYYY)?			If YES, any residual neurological defects?		
_____ / _____			_____ / _____		
Spinal Stenosis					
Have you had surgery for condition?			Other back/neck disorder		
If YES, give date of surgery:			Please describe: _____		
_____ / _____			_____		
Low Back Strain/Whiplash/Muscle Spasm					
Are you under current treatment for?					
_____ / _____					

	YES	NO		YES	NO
<b>15. Arthritis/Bone/Joint Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>			
Which family member(s) has bone/joint disease/disorder/arthritis? _____					
Arthritis					
Kind of arthritis do you have? <input type="checkbox"/> Osteoarthritis					
<input type="checkbox"/> Degenerative <input type="checkbox"/> Chronic proliferative <input type="checkbox"/> Hypertrophic <input type="checkbox"/> Arthritis deformans <input type="checkbox"/> Senile <input type="checkbox"/> Psoriatic <input type="checkbox"/> Juvenile Rheumatoid <input type="checkbox"/> Chondrocalcinosis <input type="checkbox"/> Adult Rheumatoid <input type="checkbox"/> Septic <input type="checkbox"/> Atrophic <input type="checkbox"/> Acute Infectious					
Is condition asymptomatic?			Carpal Tunnel Syndrome		
If symptomatic, date of first onset of symptoms: ____/____			Has the patient had surgery for?		
_____ / _____			_____ / _____		
Is more than one joint affected?			Ligament tears/Torn Meniscus/Osteochondritis		
If no, is the joint a hip or knee?			Dessicans/Chondromalacia		
Have you had a hip/knee replacement?			Has the patient had surgery for?		
If you had surgery, date it was done: ____/____			If surgery, date of surgery: ____/____		
_____ / _____			_____ / _____		
Characterization of disease progression/degree of disability					
<input type="checkbox"/> Mild, Minimal <input type="checkbox"/> Moderate to Severe					
Is there a joint infection?			Bone dislocation		
Osteomyelitis/Bone Infection/Bone Abscess			Was the dislocation (choose one, below)?		
Was there only a single episode?			<input type="checkbox"/> Congenital hip <input type="checkbox"/> Patella (kneecap) <input type="checkbox"/> Shoulder <input type="checkbox"/> Knee (not kneecap) <input type="checkbox"/> Hip-traumatic <input type="checkbox"/> Other joint-traumatic		
Involved joint/bone was: <input type="checkbox"/> Major joint/bone <input type="checkbox"/> Minor joint/bone			Was there a single episode of symptoms?		
			Does the patient currently have?		
			Has the patient had surgery on?		
			Dislocation was:		
			<input type="checkbox"/> Unilateral/one sided <input type="checkbox"/> Bilateral/both sides		
			Bone fracture		
			Has treatment been completed?		
			Has the patient had surgery on?		
			Was the fracture? <input type="checkbox"/> Union <input type="checkbox"/> Non-Union		
			Was the fracture of?		
			<input type="checkbox"/> Leg/hip/foot <input type="checkbox"/> Arm/hand/shoulder <input type="checkbox"/> Other bone		

Primary Applicant's Initials: \_\_\_\_\_ Spouse's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

	YES	NO		YES	NO
<b>15. Arthritis/Bone/Joint Disorder, contd.</b>					
Under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>	Rotator cuff tear	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date treatment completed:	____/____/____		Has the patient had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis/Tennis Elbow/Tendonitis/Synovitis	<input type="checkbox"/>	<input type="checkbox"/>	If YES, date of surgery:	____/____/____	
Was there only a single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	Date of original injury:	____/____/____	
Under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>	Gout/Gouty Arthritis/Hyperuricemia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Characterization of number of attacks?	<input type="checkbox"/> Few <input type="checkbox"/> Frequent	
Is underlying cause known for condition?	<input type="checkbox"/>	<input type="checkbox"/>	Are attacks well controlled by medication/diet?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please describe cause for condition below:	_____		Other bone/joint disorder	<input type="checkbox"/>	<input type="checkbox"/>
Any symptoms from?	<input type="checkbox"/>	<input type="checkbox"/>	Please describe disorder: _____	_____	
Any subsequent fractures?	<input type="checkbox"/>	<input type="checkbox"/>			
Does the patient take steroids for condition?	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
<b>16. Muscular Disorder/Lupus</b>					
Which family member(s) has muscular/connective tissue condition?	<input type="checkbox"/>	<input type="checkbox"/>	Currently being treated?	<input type="checkbox"/>	<input type="checkbox"/>
_____			If no current treatment, date treatment completed?	____/____/____	
Collagen diseases:Scleroderma/Ehlers-Danlos Syndrome/Mixed			Polymyositis/Neuromyositis/Dermatomyositis	<input type="checkbox"/>	<input type="checkbox"/>
Connective Tissue disease/ Necrotizing Angiitis	<input type="checkbox"/>	<input type="checkbox"/>	Other Muscular/Connective Tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
Lupus Erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	Please describe: _____	_____	
Fibromyalgia/Myitis/Myositis	<input type="checkbox"/>	<input type="checkbox"/>			
Currently being treated?	<input type="checkbox"/>	<input type="checkbox"/>			
If no current treatment, date of recovery:	____/____/____				
Recurrent episodes?	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
<b>17. Cancer/Tumors/Cysts</b>					
Which family member(s) has a tumor, cancer or cyst?	<input type="checkbox"/>	<input type="checkbox"/>	What was stage of the tumor?	<input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV	
_____			When diagnosed (in MMYYYY)?	____/____/____	
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Was the treatment surgery alone?	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	If not, what were the other treatments?	_____	
Thyoid Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Please describe: _____	_____	
Basal Cell/Squamous Cell Skin Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Is cancer in remission?	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Is the cancer metastatic?	<input type="checkbox"/>	<input type="checkbox"/>
Lipoma/Adipose Tumor?	<input type="checkbox"/>	<input type="checkbox"/>	Is the cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>
Colon/Rectal Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Cyst?	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma?	<input type="checkbox"/>	<input type="checkbox"/>	Please describe: _____	_____	
Other kind of cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Has the cyst been removed?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____					
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
If NO, date treatment completed:	____/____/____				

	YES	NO		YES	NO
<b>18. HIV/AIDS/ARC Autoimmune Disease</b>					
Which family member(s) has HIV, AIDS or autoimmune disease?	<input type="checkbox"/>	<input type="checkbox"/>	ARC (AIDS related complex)	<input type="checkbox"/>	<input type="checkbox"/>
_____			Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
HIV (human immunovirus)	<input type="checkbox"/>	<input type="checkbox"/>	Please describe condition: _____	_____	
AIDS (acquired immune deficiency syndrome)	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
<b>19. Any other Illness, Disease or Injury</b>					
Which family member(s) has another type of disease condition, disorder or injury?	<input type="checkbox"/>	<input type="checkbox"/>	As a result of an injury or illness have you had any of the treatments listed below?		
_____			Bone or skin graft(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Other Disease/Disease Condition/Disorder/Injury not previously described	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe other condition: _____			Loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Loss or surgical removal of organ?	<input type="checkbox"/>	<input type="checkbox"/>
_____			If YES, please describe: _____	_____	
Date of last treatment: _____					
Treating Physician: _____					

Primary Applicant's Initials: \_\_\_\_\_ Spouse's Initials: \_\_\_\_\_ Date: \_\_\_\_\_