



## 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, Pump, Omni Pod? \_\_\_\_\_

Drug / Units: \_\_\_\_\_

Date you received unit or last replacement date: \_\_\_\_\_

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)  Elevated LDL
- Large mediastinal (chest) disease (tumor less than 7.5cm)  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 \_\_\_\_\_

Calculated BMI \_\_\_\_\_

### 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 a positive view of his/her body image or does your child exhibit concerns about his/her weight.

\_\_\_\_\_

\_\_\_\_\_

9) 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: \_\_\_\_\_

Allied National, Inc., 4551 W. 107th St. #100, Overland Park, KS 66207-4037

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 \_\_\_\_\_

NEBRASKA HEALTH HISTORY

- 1. Have you or anyone applying for coverage in the past 10 years had a diagnosis of or consultation. Treatment or medication for:
a. Epilepsy or Cerebral Palsy
b. Chest Pain
c. Gastrointestinal Tract disorder
d. Cirrhosis or Hepatitis
e. Rectum, Prostate, or Hernia
f. Genitourinary System
g. Breast or Reproductive Organs
h. Adrenal Disorder
i. Thyroid or Pituitary Disorder
j. Rheumatism or Bursitis
k. Emphysema or Tuberculosis
l. Chronic Obstructive disorder or Pulmonary Disease
m. Multiple Sclerosis or Cystic Fibrosis
n. Collagen Disease
o. Leukemia or Hodgkin's Disease
p. Lymphatic Vessels or Glands
q. Any Physical Deformity or Defect
2. Has anyone applying within the last 10 years been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection or any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), significant weight loss, chronic fatigue or diarrhea, night sweats of enlarged glands?
3. Are you or any dependent (whether applying for coverage or not) currently pregnant, anticipating surgery or is anyone applying for coverage disabled, restricted or unable to perform the normal activities of daily living and self care?
4. During the past 5 years, has anyone applying for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized?
5. Is anyone currently taking medication?
6. Is there any existing medical condition or problem, including any undiagnosed symptoms that have not otherwise been indicated on this application? For "yes" answer provide details below.

Four horizontal lines for providing details for question 6.

Spoke With: \_\_\_\_\_

Name of Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_