

Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:

**Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484**

Fax (Toll Free): 888.812.6887

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!



Regence

Regence BlueCross BlueShield of Oregon

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association



Washington Individual and Family Plans

Regence BreakthruSM
Blue Selections PPO
Regence HSA Healthplan
Regence HSA Comprehensive Healthplan

WASHINGTON APPLICATION

**Thank you for selecting
Regence BlueCross BlueShield of Oregon
as your individual health plan company.**

PLEASE NOTE: THIS PLAN IS NOT A CONVERSION PLAN. IF YOU ARE APPLYING FOR CONVERSION COVERAGE FOLLOWING TERMINATION OF GROUP HEALTH BENEFITS THROUGH REGENCE BLUECROSS BLUESHIELD OF OREGON, PLEASE CALL 1 (800) 365-3155 TO OBTAIN CONVERSION INFORMATION AND ENROLLMENT FORMS.

Section 1 - Instructions

- ◆ Read carefully.
- ◆ **Use ink to complete and sign this application. An application completed in pencil will be returned to you.**
- ◆ Make sure all sections of the application are answered completely.
- ◆ You may also need to complete a Washington Standard Health Questionnaire for each family member requesting enrollment (see exceptions on page 3).
- ◆ If you need assistance completing this application, please contact your agent or call our Customer Service department at 1 (800) 365-3155.

Section 2 - Plan Selection

YOU MAY SELECT ONE MEDICAL PLAN PER APPLICATION.

I am applying for:

- New enrollment
 Addition of a dependent to my existing policy
 Change to my current individual plan
 (SKIP TO SECTION 3)

Catastrophic*	Comprehensive		HSA Catastrophic*	HSA Comprehensive
Regence BreakthruSM 50 DEDUCTIBLES: <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	Regence BreakthruSM 70 DEDUCTIBLES: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,000	Blue Selections PPO DEDUCTIBLES: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	Regence HSA Healthplan DEDUCTIBLES: Single/Family <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,500/\$7,000	Regence HSA Comprehensive Healthplan DEDUCTIBLES: Single/Family <input type="checkbox"/> \$1,500/\$3,000
You must receive care from Regence BlueCross BlueShield of Oregon Preferred Providers in order to receive maximum benefits under this plan.			You must receive care from Regence BlueCross BlueShield of Oregon Participating Providers in order to receive maximum benefits under this plan.	

DENTAL (optional)

- I wish to enroll in the optional Individual Dentacare plan for an additional monthly premium.
 Disenroll all family members on my policy from Individual Dentacare. I understand that I/we cannot reenroll for 9 months.
Please note: Individual Dentacare must be purchased with one of our medical plans, dental only coverage is not available. If selected, Individual Dentacare must be added for all applicants listed on this form.

***Enrollment in a catastrophic health plan may not provide portability if you later decide to enroll in another individual health plan. "Portability" means that you will receive credit for a plan's preexisting condition waiting period based on prior coverage. By enrolling in a catastrophic plan, you may lose portability rights and have to satisfy the nine-month preexisting condition waiting period, should you later change to another individual health plan.**

You may request an effective date of coverage in the future (no more than 90 days later than the date you signed the application). Effective dates are available on the 1st and 15th of each month following acceptance and approval.

Please indicate month _____ **1st of the month** **15th of the month**

(Please initial) X "My employer is not paying the premium for this individual policy (including cafeteria plans)."

Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees. For information on small employer health benefit plans, contact the Regence BlueCross BlueShield of Oregon (Regence BCBSO) Group Marketing department at (503) 225-5406.

Section 3 - Enrollment Information

LIST ALL FAMILY MEMBERS TO BE COVERED

OFFICE USE	Last Name of Family Member	First Name, Middle Initial	Sex	Age	Birthdate	Social Security Number	OFFICE USE: OED
31-1	Applicant						
32-1	Legal Spouse						
33-1	Child						
33-1	Child						
33-1	Child						
33-1	Child						

Explain the relationship to the applicant for any person(s) listed above whose last name is different from the applicant's.

RESIDENCE ADDRESS

Name	
Residence/Mailing Address	PO Box (if applicable)
City, State, ZIP Code	OFFICE USE CO CODE
Home Phone Number ()	Work Phone Number ()
County	

BILLING ADDRESS (complete only if billing should be sent to an address other than listed above)

Name	
c/o	
Address	City, State, ZIP Code

To be eligible for coverage, you must be a permanent resident of Clark County, in the State of Washington. In order to process your application, we need proof of your place of residency. Please include a photocopy of one of the following with your application: 1) Washington State driver's license, 2) Washington State ID Card, 3) Voter registration card, or 4) current utility bill.

Please Note: The address on your proof of residency must match your address listed on the application.

Yes No Do you or any family members listed on this application use tobacco in any form?

Section 4 - Preexisting Conditions

This contract has a 9-month waiting period for preexisting conditions. However, you and each family member will be credited for each month of prior creditable coverage toward the preexisting conditions waiting period if any of the following situations apply to you. *Please complete section 5, Other Coverage Information below.*

- PRIOR COVERAGE:** Within the last 63 days, applicant or dependent had health plan coverage. *Include a copy of your certificate(s) of coverage.**
- RELOCATION:** Applicant has relocated to Clark County from another part of Washington State within the last 90 days, and prior plan is no longer available. *Include a photocopy of a utility bill in your name showing the prior address (not more than 90 days prior to the date of this application.)*
- PROVIDER CANCELLATION:** Applicant's provider has left the prior plan's network within the last 90 days prior to the date of this application and is in this plan's network. Prior plan must have been an individual plan, not group. *Include a copy of a letter of verification from the provider or carrier.*

Section 7 - Certification, Authorization and Signature

Be sure to sign and date the application below. Spouse's signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence BlueCross BlueShield of Oregon (Regence BCBSO) to enroll in their coverage. I understand that Regence BCBSO will reply on each answer in making coverage and rating determinations. For the protection of all our members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence BCBSO may result in Regence BCBSO taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. If coverage is rescinded for fraud or intentionally misleading statements, Regence BCBSO will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BCBSO in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence BCBSO. Regence BCBSO may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I further affirm that I received a disclosure statement and outline of coverage from Regence BCBSO or its authorized agent describing the individual contract.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence BlueCross BlueShield of Oregon may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at www.regence.com or by telephone request at 1 (800) 365-3155.

X Signature of applicant or current contract holder, parent or legal guardian if applicant is under 18 years of age or legally incompetent*	Relationship	Date
X Signature of applicant's legal spouse*		Date
X Signature of dependent(s) over 18 years of age*		Date

* If signature by a personal representative of the member/enrollee please complete the following:

Personal Representative's Name (please print) _____

Relationship to Individual _____ (Attach legal documentation if other than parent of a minor child)

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

Section 8 - Premium Billing Options (if application is approved)

PLEASE DO NOT SEND MONEY WITH THIS APPLICATION.

Please indicate one billing option:

- Monthly (checking account deductions - see below)
- Quarterly Bill (every three months)
- Monthly Bill

SUREPAY AUTHORIZATION

Surepay is a simple and convenient way to keep your health coverage in force. If you select the Surepay option of paying for your Regence BCBSO health insurance the payment will be deducted automatically from your account on the 3rd business day of the month or 15th of the month depending on your effective date of coverage. This will provide several advantages to you:

- ◆ Your payment will always be made on time (if funds are available in your account).
- ◆ You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- ◆ Your monthly bank statement will show a withdrawal notation which is your receipt of payment.
- ◆ Please pay your paper bill until you are notified that your electronic funds transfer has been started. Processing may take up to 60 days.

GETTING STARTED is as easy as 1 - 2 - 3:

1. **Complete**, date and sign the authorization below.
2. **Write** "void" on one of your checks.
3. **Return** this completed form and your "voided" check (not a deposit slip).

SOME SUGGESTIONS:

- ◆ **Check register reminder:** When you receive your monthly statement be sure to enter the payment amount in your check register. This will help you keep your account in balance and avoid overdraft problems.
- ◆ **If you change your bank or wish to cancel your automatic deduction.**
 1. Do this at least 15 days before your next premium is due. We suggest you leave enough money in your old bank account to cover your payments in case there is a delay in processing the change.
 2. Just send us a copy of your new "voided" check and a note explaining that you have changed banks.
 3. Changes may also be made by calling Customer Service at 1 (800) 365-3155.

SUREPAY AUTHORIZATION

- 1. COMPLETE** and sign this authorization form. **2. ATTACH** your voided check (**not** a deposit slip).
3. RETURN to Regence BlueCross BlueShield of Oregon (PO Box 1271, MS5K, Portland, OR 97201-1271).

AUTHORIZATION TO MY BANK

Checking Account Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Oregon, Portland, Oregon. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution	Transit/Routing Numbers	Account Number

 Account Holder's Name (please print)

▶ _____
 Account Holder's Authorized Signature(s) - as it appears on bank records

 Date

Section 9 - Producer Certification

FOR INSURANCE PRODUCER USE ONLY

I, (the Producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BCBSO. I have informed the applicant that the effective date of coverage is assigned only by Regence BCBSO, and provided the disclosure information required.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Producer Name (please print or type)	Producer e-mail	Regence BCBSO Producer Number
Agency Name	Phone Number ()	Fax Number ()
Street Address	City	State ZIP Code
Producer's Signature (required) X	Date	
PRODUCER: COLLECT NO PREMIUM WITH APPLICATION		

Section 10 - Washington Individual and Family Plans Application Checklist

Thank you for completing, signing, and dating this Washington Individual and Family Plans Application.

Effective January 1, 2001, Washington State law requires that anyone applying for individual health coverage **MUST COMPLETE BOTH AN APPLICATION FORM FROM THE CARRIER AND A WASHINGTON STANDARD HEALTH QUESTIONNAIRE** (One questionnaire form is required for each family member applying for coverage. See Section 6 for exceptions).

We have provided a checklist below to help ensure that your application is complete, and to avoid any unnecessary delay in the processing of your application.

- I have used ink when completing this application.
- I have chosen a plan in Section 2 and an Individual Dentacare plan (if desired).
- I have read and initialed in Section 2 that my employer is not paying for premiums for this application.
- I have provided all requested information about all family members in Section 3.
- I have completed section 4.
- I have completed section 5, and provided all requested information for each family member. I have provided a copy of a certificate of coverage, if applicable.
- I have completed Section 6 and included proof of the exception, if applicable.
- I have carefully read Section 7 and I have signed and dated the application in the space(s) indicated. Furthermore, I understand that this application cannot be processed if it is incomplete or if I have not signed and dated this application. The incomplete application will be returned to me and this will delay processing.
- My spouse has read, signed, and dated this application if he/she is listed in Section 3 of this application.
- My dependents over 18 years of age, if listed in Section 3 of this application, have read, signed and dated this application.
- A parent or legal guardian has completed and signed this application for children under age 18, if applicable.
- I have not attached my premium payment with this application. I understand that Regence BCBSO will bill me upon acceptance.
- I have chosen a billing option in Section 8. (Note: If selecting automatic bank withdrawal, upon acceptance, please pay your paper bill until you are notified that your electronic funds transfer has been initiated. Processing may take up to 60 days.)
- I have completed a Washington Standard Health Questionnaire for myself and each family member applying for coverage. (See Section 6 for exceptions).



Regence

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Do not send payment with your application. We will bill you upon acceptance of your application.

**Please return this application to:
 Regence BlueCross BlueShield of Oregon
 Attn: Individual Enrollment Services, Mail Station E-8U
 P.O. Box 1271
 Portland, OR 97207-1271
 1 (800) 365-3155**

FOR OFFICE USE ONLY					
Additional telephone information received by Regence BlueCross BlueShield of Oregon					

FOR OFFICE USE ONLY	Group Number	Identification Number	S	Agent Number	Cont. Effective Date	Bill Per
1						
5	6	17	30			65

STANDARD HEALTH QUESTIONNAIRE FOR WASHINGTON STATE

Recertified for Coverage Beginning On or After April 1, 2008

Revised for Use On and After July 26, 2009, In Compliance with ESHB 1401 Enacted by the 2009 Washington State Legislature



TURN PAGE TO BEGIN THE QUESTIONNAIRE ►

ARE YOU EXEMPT FROM TAKING THIS QUESTIONNAIRE?

Answer the following questions before you fill out the questionnaire to determine if you meet one of these exemptions.

If you do not know the answer to a question, do not fill out this questionnaire. Please contact your agent or health carrier to whom you are applying for further instructions. You may be asked to provide further documentation to support your responses to the following questions.

If you answer “Yes” to any of the following questions, do not complete the health questionnaire. You may apply to the health carrier without taking the questionnaire.

If you answer “No” to all of the following questions, this page must be completed along with Sections II and III of the questionnaire. Submit the completed questionnaire to the health carrier with your application.

1. Are you eligible for Medicare?	Yes <input type="radio"/>	No <input type="radio"/>
2. Have you changed residences from one part of Washington state to another part where your current health plan is not offered, <u>and</u> you are submitting your application within 90 days of relocation?	Yes <input type="radio"/>	No <input type="radio"/>
3. Is your health care provider no longer part of the provider network on your current individual health plan? To answer yes, <u>all</u> of the following must be true: a. Your health care provider is on the new health plan you are applying for; <u>and</u> b. You received services from that provider during the 12 months before he or she left your current health plan; <u>and</u> c. You are submitting your application to the new health plan within 90 days of your provider leaving your current health plan's network.	Yes <input type="radio"/>	No <input type="radio"/>
4. Are you applying for individual health coverage within 90 days of using up your COBRA* coverage? (This includes loss of COBRA coverage due to your employer going out of business or discontinuing its health plan while you are on COBRA.) To answer yes, you must have used up your COBRA coverage for any reason other than misrepresentation, gross misconduct, or failure to pay your premium.	Yes <input type="radio"/>	No <input type="radio"/>
5. Have you been covered by a group plan provided by an employer that is exempt from COBRA, <u>and</u> you are applying for individual health coverage within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA, <u>and</u> you had at least 24 months of continuous group coverage prior to such event?	Yes <input type="radio"/>	No <input type="radio"/>
6. Are you applying for individual health coverage within 90 days of terminating your COBRA coverage <u>and</u> you had at least 24 months of continuous group coverage prior to termination? (Not applicable to BHP applicants.)	Yes <input type="radio"/>	No <input type="radio"/>
7. Are you applying for individual health coverage within 90 days of an event which qualifies you for COBRA, <u>and</u> you had at least 24 months of continuous group coverage prior to such event but you choose not to take COBRA coverage? (Not applicable to BHP applicants.)	Yes <input type="radio"/>	No <input type="radio"/>
8. Have you been enrolled in the Washington State Basic Health Plan for at least 24 continuous months, and you are submitting your application within 90 days of disenrollment?	Yes <input type="radio"/>	No <input type="radio"/>
9. Are you adding coverage to your existing individual policy for your newborn or adopted child who has been born or placed for adoption with you within the last 60 days?	Yes <input type="radio"/>	No <input type="radio"/>

* COBRA refers to the federal law that requires certain employers to continue health coverage temporarily for certain former employees, retirees, spouses and dependents, at their expense when coverage is lost due to certain specific events. For more information about COBRA rules, go to the U.S. Dept. of Labor website: <http://www.dol.gov/ebsa/faqs>

SECTION I. INFORMATION ABOUT THE HEALTH QUESTIONNAIRE

YOUR PRIVACY RIGHTS

- By completing this form, you are giving your medical information to the insurance carrier. Under Washington State RCW 48.43.021, except as otherwise required by statute or rule, a carrier and the Washington State Health Insurance Pool (WSHIP), and persons acting at the direction of or on behalf of a carrier or WSHIP, shall not disclose an applicant's personally identifiable health information unless such disclosure is explicitly authorized in writing by the person who is the subject of the information. Each carrier issues its own "consumer privacy statement" and maintains its own privacy policies.

INFORMATION ABOUT THE STANDARD HEALTH QUESTIONNAIRE

- The Standard Health Questionnaire was created by the Washington State Health Insurance Pool (WSHIP). It is used by insurance carriers to determine the eligibility of people who apply for private, individual medical coverage.
- If you are applying for family coverage, a separate questionnaire must be completed for each family member.
- Do not send medical records with this questionnaire. The carrier is not allowed to consider any medical information except what you provide on this questionnaire. If you are rejected for coverage and appeal the rejection, the carrier may then request further medical information which you may choose to provide if you believe it will assist the carrier in correctly scoring your questionnaire.
- Any time you apply for individual coverage, or change from one carrier to another, a new health questionnaire will be required unless you are exempt from taking the questionnaire (see the list on the previous page, page 2).
- Your signed questionnaire will be valid for a 90-day period. If you wait more than 90 days to submit your application, you will have to complete a new health questionnaire.

SCORING YOUR HEALTH QUESTIONNAIRE

- The insurance carrier uses a standard scoring system designed by WSHIP to score your questionnaire.
- The scoring system document can be viewed and printed from WSHIP's website, <https://www.wship.org/shq.asp>; the scoring document is also available from the carrier you are applying to or from your insurance agent.
- **Questions about the scoring of your questionnaire must be directed to the insurance carrier you are applying with, or your insurance agent, but not to WSHIP.**

IF YOU ARE DENIED COVERAGE BECAUSE OF YOUR SCORE

- If the carrier rejects your application because of your score you must be sent a rejection notice within 15 business days after the carrier has received your completed application and health questionnaire. To be “complete” this questionnaire must be signed and dated with no missing information that might affect your score.
- The carrier will mail you information about coverage available through WSHIP. WSHIP was established by the state legislature to offer insurance coverage for state residents who are rejected for coverage in the individual market. Your insurance agent can also provide this information to you, or you can contact WSHIP toll-free at 1-800-877-5187, or at www.wship.org. **You must apply for WSHIP coverage within 90 days of the date your notice of rejection from the carrier is postmarked in order to be eligible to enroll in WSHIP.**
- You may request an appeal of your score as described below.

HOW TO APPEAL YOUR SCORE

- You may request a review of your score if you think the carrier did not score your questionnaire correctly or did not respond within the required timeframe.
- To request a review of your score, **contact the insurance carrier directly in writing. Do not contact WSHIP to appeal your score.**
- You may apply for coverage with WSHIP during the time that your appeal is under review. (See contact information below).
- If the carrier does not complete its review of your appeal within 30 calendar days of their receipt of your appeal request, or if you have exhausted your appeal rights with the insurance carrier, you may request a review from WSHIP.
- WSHIP’s review is limited to whether the carrier correctly applied the scoring system for the questionnaire and whether the carrier’s notice of rejection for coverage was provided or postmarked within 15 business days of the carrier’s receipt of your completed application.
- Within five business days of receipt of your request, the WSHIP administrator will respond to you confirming receipt of your request, the date it was received, the nature of the complaint and the resolution requested.
- Send your written request for review to WSHIP along with:
 - A copy of your completed health questionnaire;
 - The carrier’s score of your questionnaire;
 - A copy of your written appeal request to the carrier; and
 - A copy of the carrier’s written denial of your appeal, if applicable.
- Mail to: Appeals, WSHIP, P.O. Box 1090, Great Bend, KS 67530. A copy of WSHIP’s operating rules governing requests for health questionnaire reviews is available at <https://www.wship.org/appeals.asp> or call the WSHIP Administrator toll-free at 1-800-877-5187.
- WSHIP will investigate your appeal and make its decision within 30 days of receipt of the complete information needed to respond to the appeal. WSHIP will notify you and the carrier of its decision.
- Contact WSHIP if you wish to enroll with WSHIP during your appeal review period.

DEFINITIONS: The following is a **list of terms** used in this questionnaire. These definitions will help you fill out the questionnaire, if you do not understand any terms used.

- **Acute** (as opposed to **Chronic**): Typically sudden onset, and resolving after a single course of treatment or therapy. Many are infectious in origin. Examples include pneumonia, gastritis, urinary tract infections, and minor trauma not requiring surgery.
- **Benign** (as opposed to **Malignant**) implies a mild and non-progressive disease.
- **Chronic** (as opposed to **Acute**): A repetitive illness, that may or may not improve over time. Chronic illnesses can last from weeks to years. Examples include heart failure, COPD, leukemia, and many of the psychiatric illnesses such as depression and schizophrenia.
- **Diagnosed** means a medical condition or disease has been identified by a licensed physician or medical professional who has a license to practice medicine.
- **Major** (as opposed to **Minor**): These illnesses frequently require the use of many medications and if not addressed promptly and thoroughly, can lead to serious long-term complication and possibly death. Many evolve into chronic illnesses. Examples include coronary heart disease, Type 1 diabetes, stroke, and renal (kidney) failure.
- **Malignant** (as opposed to **Benign**) is a medical term used to describe a severe and progressively worsening disease.
- **Medicated** means you are taking a drug prescribed by a licensed physician or other licensed medical professional for the treatment of a medical (including mental) condition.
- **Minor** (as opposed to **Major**): Illnesses that are cured with a single or limited number of medications or treatment and there are no ongoing complications. These illnesses do not extend to other organs if treated appropriately, and are managed by one or two visits to a physician. Examples include: conjunctivitis (pink eye), minor skin trauma such as lacerations (cuts), and pharyngitis (sore throat).
- **Operated** means you have had surgery performed by a licensed physician or other licensed medical professional.
- **Trauma:** Physical trauma is an injury to any tissue by physical or chemical means. This may include abrasions, lacerations, incisions, stab, puncture, or bullet wounds. When trauma occurs to the bone, this can result in fractures, dislocations, or sprains. Trauma can also be the result of exposure to toxic chemicals, high heat, irradiation, or electrical shock, as these can all cause damage to tissues and organs. Psychological trauma is the result of having an emotionally stressful situation occur that can be painful, distressing or shocking. These frequently result in lasting emotional, as well as physical, complications.
- **Treated** means you have received recommended medical care, or your medical (or mental) condition has been diagnosed and no treatment was recommended, or you are taking prescribed medications or being monitored for an illness or injury by or under the direction of a licensed physician or other licensed medical professional.

SECTION II. INSTRUCTIONS AND INFORMATION ABOUT YOU

TO FILL OUT THE QUESTIONNAIRE TAKE THE FOLLOWING STEPS:

1. Answer the questions to the best of your ability.
2. Make sure you **SIGN and DATE** this health questionnaire on the last page of this document.
3. In each section, answer the questions in the **bold boxes** first.
4. How you answer those questions will then inform you if you need to indicate a medical condition you may have (or had) in the **tables of conditions** that follow.
5. If you answered **NO** to the first bold question in each section, you can move on to the next section.
6. If you answered **YES** to having a certain medical condition, look at the detailed table of conditions to help you identify which specific condition(s) you may have or had.
7. Once you have looked at the conditions, **fill in the circle for the condition** you have or had.
8. Once you indicated having a specific condition, **move across the table** to answer questions related to the year you were diagnosed, if you had surgery for this condition (or surgery was recommended in the last 6 months), and when you were last operated on, treated, or medicated for that condition.
9. Mark all conditions you have or had. This includes any conditions which resulted from another primary diagnosis. For example, for cancers that have metastasized, mark all types of cancer for which you have been diagnosed, treated, and/or medicated.
10. If you have any **other medical condition(s)** not listed anywhere on the questionnaire, you will have the chance to write down this condition in Section (M) of the questionnaire.
11. If you are the **parent or guardian** who is filling out this questionnaire for a child or individual with disabilities, please answer the questions as if "you" means the child or disabled individual.

Do not say you have a condition unless a doctor or other licensed medical care provider told you that you have or had a condition. **Be sure to mark all of the conditions you have or had.**

ABOUT YOU – YOU MUST FILL IN THE FOLLOWING INFORMATION ABOUT YOURSELF:

First Name	M.I.	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth	Contact Phone Number	Height
<input type="text"/> / <input type="text"/> / <input type="text"/>	(<input type="text"/>) <input type="text"/> - <input type="text"/>	Feet Inches Weight
Email Address		
<input type="text"/>		
Gender		
<input type="text"/> Are you male or female? <input type="radio"/> Male <input type="radio"/> Female		

QUESTIONS? IF YOU HAVE QUESTIONS ABOUT THIS QUESTIONNAIRE – call the insurance carrier that you are submitting it to or your insurance agent.

A. Medical Conditions

Have you been diagnosed, treated and/or medicated for any of the following conditions within the last 10 years? Please answer yes or no below.

Do not answer YES that you have or had a medical condition unless a doctor or other licensed medical care provider told you that you have or had this condition.

<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW. WHEN YOU HAVE COMPLETED THIS SECTION, YOU MAY CHOOSE TO ANSWER EACH SECTION (B) THROUGH (M), OR YOU MAY PROCEED TO SECTION (N).
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION AND COMPLETE SECTIONS (B) – (N).

A. Medical Conditions - List of conditions:		Fill in which condition you have (or had)	If you filled in a condition, what year were you diagnosed?
1	AIDS	<input type="radio"/>	
2	Amyotrophic lateral sclerosis - ALS - Lou Gehrig's Disease	<input type="radio"/>	
3	Autism - Severe: minimal and inappropriate interaction with others, repetitive or restrictive behaviors (hand flapping, head rolling, self injury), limited or no speech, frequently requiring placement into a special education setting	<input type="radio"/>	
4	Bilateral (left and right) leg amputation	<input type="radio"/>	
5	Biliary atresia (congenital blockage of bile duct)	<input type="radio"/>	
6	Blood & lymphatic system or lymph nodes – cancer, except leukemia (e.g., lymphoma, multiple myeloma)	<input type="radio"/>	
7	Brain degeneration (progressive loss of brain function)	<input type="radio"/>	
8	Brain injury resulting in a deep coma	<input type="radio"/>	
9	Central nervous system (brain or spinal cord) abnormal development prior to birth	<input type="radio"/>	
10	Cerebral Palsy (CP)	<input type="radio"/>	
11	Cervical (neck) Spina Bifida	<input type="radio"/>	
12	Cervical spinal (neck) fracture resulting in injury to the spinal cord	<input type="radio"/>	
13	Chronic or acute renal failure, with or without End Stage Renal Disease – ESRD	<input type="radio"/>	
14	Chronic pulmonary heart disease (e.g., right heart disease)	<input type="radio"/>	
15	Congenital hypothyroidism (cretinism)	<input type="radio"/>	
16	Coronary artery disease (heart disease) or a heart valve (mitral, aortic) disorder, without heart attack, requiring surgery including cardiac catheterization, angioplasty (balloon and/or stent), coronary artery bypass surgery (CABG), and/or heart valve surgery	<input type="radio"/>	
17	Coronary artery disease (heart disease), with heart attack, requiring surgery including cardiac catheterization, angioplasty (balloon and/or stent), coronary artery bypass surgery (CABG), and/or heart valve surgery, or with cardiac complications	<input type="radio"/>	

TABLE CONTINUED ON NEXT PAGE

A. Medical Conditions - List of conditions:		Fill in which condition you have (or had)	If you filled in a condition, what year were you diagnosed?
18	Cystic fibrosis	<input type="radio"/>	
19	Down's Syndrome	<input type="radio"/>	
20	Encephalitis due to a bacterial or viral origin	<input type="radio"/>	
21	Fetal damage resulting from medication usage	<input type="radio"/>	
22	Fetal immaturity: less than 24 weeks or less than 1lb at birth and with problems if more than 5 years old	<input type="radio"/>	
23	Fragile X Syndrome	<input type="radio"/>	
24	Hemophilia	<input type="radio"/>	
25	HIV sero-positive, without AIDS	<input type="radio"/>	
26	Huntington's Chorea	<input type="radio"/>	
27	Intestinal perforation or rupture that resulted in peritonitis (abdominal infection), a colostomy and/or ileostomy, septicemia (infection of the blood), and/or septic shock	<input type="radio"/>	
28	Lymphoma (cancerous tumor of the lymph tissue or lymph nodes, e.g., Hodgkin's Disease) - advanced or having spread to involve multiple lymph nodes or other organs	<input type="radio"/>	
29	Mitral or aortic valve narrowing (stenosis) or insufficiency	<input type="radio"/>	
30	MRSA (staph) infection - severe or complicated	<input type="radio"/>	
31	Mucopolysaccharidoses (e.g., Hunter's Syndrome)	<input type="radio"/>	
32	Multiple myeloma	<input type="radio"/>	
33	Multiple Sclerosis (MS)	<input type="radio"/>	
34	Muscular Dystrophies (e.g., Duchenne (DMD), Becker (BMD), Emery-Dreifuss (EDMD), Limb-girdle (LGMD), Facioscapulohumeral (FSHD), Myotonic (MMD), Congenital (CMD), and Pompe Disease)	<input type="radio"/>	
35	Necrotizing fasciitis (flesh-eating bacterial infection)	<input type="radio"/>	
36	Nephrotic (kidney) Syndrome (nephrosis)	<input type="radio"/>	
37	Peritonitis (inflammation/infection of the abdominal lining)	<input type="radio"/>	
38	Psychotic or schizophrenic disorders	<input type="radio"/>	
39	Reticulosarcoma (e.g., Non-Hodgkin's Lymphoma)	<input type="radio"/>	
40	Rheumatic heart disease with complication (heart valve damage, anemia)	<input type="radio"/>	
41	Septicemia (blood infection) with health conditions resulting in complications, such as infection to other body parts	<input type="radio"/>	
42	Severe burns on more than 50% of one's body	<input type="radio"/>	
43	Spinal abscess (infected area)	<input type="radio"/>	

TABLE CONTINUED ON NEXT PAGE

A. Medical Conditions - List of conditions:		Fill in which condition you have (or had)	If you filled in a condition, what year were you diagnosed?
44	Spinal cord injury affecting the lumbar region (L1-L5), sacral region (S1-S5), and/or the coccyx	<input type="radio"/>	
45	Subdural hematoma (blood clot on the brain) with complications (e.g., loss of speech, sight, memory; paralysis)	<input type="radio"/>	
46	Thoracic (middle back) spinal cord injury	<input type="radio"/>	
47	Transplants (other than cornea)	<input type="radio"/>	
48	Tuberculosis (TB) pulmonary (lung)	<input type="radio"/>	
49	Ulcerative colitis	<input type="radio"/>	
50	Wegener's Granulomatosis	<input type="radio"/>	

- If you answered “YES” to Section (A), you may choose to answer each Section (B) through (M), or you may skip to Section (N).
- If you answered “NO” to Section (A), please continue to the next page and complete Sections (B) through (N).

B. Cancer or Benign Tumors

Cancer (malignancy) develops when cells in a part of the body begin to grow out of control. Although there are many kinds of cancer, they all start because of out-of-control growth of abnormal cells. Normal body cells grow, divide, and die in an orderly fashion. Because cancer cells continue to grow and divide, they are different from normal cells. Sometimes these cells form tumors, which are abnormal growths of body tissues. Not all tumors are cancerous.

Have you been diagnosed, treated and/or medicated for cancer or a benign tumor in the last 10 years?	
Do not answer YES if you have or had cancer or a benign tumor unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CANCER(S) OR BENIGN TUMOR(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (C) ON CIRCULATORY, BLOOD OR HEART CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the **type** of cancer or tumor you have or had
2. **Second**, if you filled in the circle for a type of cancer or tumor, indicate the **year** of your diagnosis
3. **Third**, if you filled in the circle for a type of cancer or tumor, indicate if it was ever operated on **or if surgery has been recommended in the last 6 months**
4. **Fourth**, if you filled in the circle for a type of cancer or tumor, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

B. Cancer or Benign Tumor(s) What type of cancer(s) or tumor(s) do you or did you have in the last 10 years? <u>If you have or had cancer, mark all sites of the cancer, including secondary cancers (metastasis).</u> Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
51	Bone and connective tissue – benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
52	Bone cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
53	Breast - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
54	Breast cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
55	Central nervous system (brain and spinal cord) – benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
56	Central nervous system (brain and spinal cord) cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
57	Ear/nose/throat - benign tumor (e.g., Cystic hygroma)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
58	Ear/nose/throat cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
59	Eye, external - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
60	Eye, external, cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
61	Eye, internal - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
62	Eye, internal, cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

B. Cancer or Benign Tumor(s) What type of cancer(s) or tumor(s) do you or did you have in the last 10 years? <u>If you have or had cancer, mark all sites of the cancer, including secondary cancers (metastasis).</u> Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes			Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
63	Female genital tract (ovary, uterus, cervix, vagina) - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
64	Female genital tract (ovary, uterus, cervix, vagina) cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
65	Genitourinary (testicular, kidney, ureter, urinary bladder, urethra) cancer, not including prostate	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
66	Hepatobiliary system (liver, gall bladder, bile duct) cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
67	Intestine or abdominal cavity - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
68	Intestine or abdominal cavity cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
69	Leukemia	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
70	Pancreatic gland cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
71	Peripheral nerves (nerves other than the brain or spinal cord) - tumor (cancerous or benign)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
72	Pituitary, adrenal, or parathyroid gland - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
73	Pituitary, adrenal, or parathyroid gland cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
74	Prostate - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
75	Prostate cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
76	Pulmonary system (lungs, bronchi, trachea) - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
77	Pulmonary system (lungs, bronchi, trachea) cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
78	Rectum or anus - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
79	Rectum or anus cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
80	Skin - benign abnormal growth	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
81	Skin cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82	Stomach or esophagus - benign tumor	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
83	Stomach or esophagus cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
84	Thyroid gland cancer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

C. Circulatory, Blood or Heart Conditions

Our vascular system is made up of blood vessels, which are part of our circulatory or cardiovascular system that works with the beating heart. With each beat, the heart pumps blood into the vessels and throughout the body, providing nutrients and oxygen to cells. The circulating blood removes waste products, toxins and other harmful substances. Our circulatory system is critical to many body functions, especially our respiratory or lung function, digestion, waste removal and body temperature. Medical conditions can occur when these systems are not working properly.

Have you been diagnosed, treated and/or medicated for blood, circulatory or heart conditions in the last 10 years?

Do not answer YES if you have or had a circulatory, blood or heart condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.

<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (D) ON DIGESTIVE CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

C. Circulatory, Blood or Heart Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
What type of circulatory, blood or heart condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
85	Aortic aneurysm (balloon-like weakened area)	<input type="radio"/>	Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
86	Arterial aneurysm, except aorta	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
87	Arterial disease - major and noninflammatory (e.g., renal artery hyperplasia) or embolism (any substance that stops the flow of blood) or thrombosis (blood clot) of artery	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
88	Arterial inflammation (e.g., vasculitis, arteritis)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
89	Arterial trauma (physical injury to an artery)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
90	Atherosclerosis (hardening of the arteries)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
91	Blood – major non-cancerous diseases (e.g., thalassemia major, thrombocytopenia, purpura, but excluding hemophilia)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

C. Circulatory, Blood or Heart Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
What type of circulatory, blood or heart condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
92	Blood – minor non-cancerous diseases (e.g., thalassemia minor, polycythemia vera: excess red blood cells)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
93	Cardiac (heart) infections (e.g., myocarditis or endocarditis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
94	Cardiac congenital (occurring at or before birth) disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
95	Conduction disorders (abnormal heartbeat – fast, slow or irregular heart rhythm) e.g., bundle branch block, sick sinus syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
96	Congestive Heart Failure (CHF)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
97	Coronary artery disease, with heart attack, <u>anterior wall, not requiring surgery</u> such as cardiac catheterization, angioplasty (balloon and/or stent), coronary artery bypass surgery (CABG), and/or heart valve surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
98	Coronary artery disease, with heart attack, <u>inferior wall, not requiring surgery</u> such as cardiac catheterization, angioplasty (balloon and/or stent), coronary artery bypass surgery (CABG), and/or heart valve surgery, and <u>without complications</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
99	Embolism (any substance that stops the flow of blood) or thrombosis (blood clot) of veins	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
100	Hepatitis (A, B, or C) – infectious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
101	Hyperlipidemia – high cholesterol (if known, HDL/LDL is less than 0.3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
102	Hypertension – benign (high blood pressure with no signs of illness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
103	Hypertension – malignant (high blood pressure 200/140, with persistent headache, vision problems, and kidney problems)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

C. Circulatory, Blood or Heart Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
What type of circulatory, blood or heart condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
104	Ischemic heart disease, except Congestive Heart Failure (CHF) – (blocked heart arteries, either partial or complete without a heart attack)	○	○	○	○	○	○
105	Lipidoses – unable to process fats (e.g., Fabry's disease, Gaucher's disease, Krabbe's disease, Niemann-Pick disease, Refsum's disease, Tay-Sachs disease, Wolman's disease)	○	○	○	○	○	○
106	Lymphatic tissue disorders that are non-cancerous (e.g., Splenomegaly - enlarged spleen or lymphedema)	○	○	○	○	○	○
107	Phlebitis (vein inflammation) and thrombophlebitis (clot)	○	○	○	○	○	○
108	Pulmonary heart disease, without heart attack	○	○	○	○	○	○
109	Septicemia (blood infection) without complications	○	○	○	○	○	○
110	Sickle cell anemia	○	○	○	○	○	○
111	Valve disorder (aortic, mitral) with complications such as heart failure, enlarged heart, or irregular heartbeat	○	○	○	○	○	○
112	Valve disorder (aortic, mitral) without complications	○	○	○	○	○	○
113	Varicose veins of lower extremity	○	○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

D. Digestive Conditions

When you eat, your body breaks food down to a form it can use to build and nourish cells and provide energy. This process is called digestion. Your digestive system is a series of hollow organs joined in a long, twisting tube. It runs from your mouth to your anus and includes your esophagus, stomach, and small and large intestines. Your liver, gallbladder and pancreas are also involved. They produce juices to help digestion. There are many types of digestive disorders and conditions. The symptoms vary widely depending on the problem.

Have you been diagnosed, treated and/or medicated for digestive conditions in the last 10 years?	
Do not answer YES if you have or had a digestive condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (E) ON ENDOCRINE, LYMPHATIC, OR METABOLIC CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

<u>D. Digestive Conditions</u> What type of digestive condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
114	Bowel obstruction/blockage	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
115	Cirrhosis (liver)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
116	Diverticulitis (inflammation/infection of the colon)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
117	Esophagus – inflammation	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
118	Gastritis (inflammation/infection of the stomach) and/or duodenitis (small intestine)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
119	Hepatobiliary system (liver, gall bladder, bile duct) - trauma (physical injury)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
120	Hernia – hiatal	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
121	Intestine and abdomen problems due to birth and genetics (e.g., Meckel's diverticulum, congenital obstructions, occlusions)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

D. Digestive Conditions What type of digestive condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes			Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
122	Intestines & abdomen – inflammation (e.g., Inflammatory Bowel Disease (IBD), ileitis, colitis, Crohn’s Disease)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
123	Intestines & abdomen - trauma (physical injury)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
124	Intestines & abdomen – vascular (blood vessel) disease (e.g., mesenteric infarction, intestinal ischemia)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
125	Irritable Bowel Syndrome (IBS)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
126	Pancreas - benign endocrine disorder (e.g., Zollinger-Ellison syndrome, pseudopapillary tumor of the pancreas, cystadenoma of the pancreas)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
127	Pancreatitis (inflammation/infection of the pancreas), acute or short term	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
128	Pancreatitis (inflammation/infection of the pancreas), chronic or ongoing	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
129	Peptic (stomach) ulcer	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
130	Rectum or anus – infections (e.g., Human Papillomavirus (HPV) infection)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
131	Rectum or anus – inflammation (e.g., hemorrhoids, proctitis)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
132	Stomach or esophagus – trauma (physical injury) or anomaly (malformation, occlusion, obstruction), e.g., pyloric stenosis	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

E. Endocrine, Lymphatic or Metabolic Conditions

The foundations of the endocrine system are the hormones and glands. As the body's chemical messengers, hormones (pronounced: hor-moanz) transfer information and instructions from one set of cells to another. Too much or too little of any hormone can be harmful to your body. The lymphatic system clears away infection and keeps your body fluids in balance. Lymph vessels, which are different from blood vessels, carry fluid called lymph throughout your body. If it's not working properly, fluid builds in your tissues and causes swelling. Other lymphatic system problems can include infections, blockage, and cancer. Metabolism is the process your body uses to get or make energy from the food you eat. Chemicals in your digestive system break the food parts down into sugars and acids, your body's fuel. A metabolic disorder occurs when abnormal chemical reactions in your body disrupt this process.

Have you been diagnosed, treated and/or medicated for an endocrine, lymphatic or metabolic condition(s) in the last 10 years?

Do not answer YES if you have or had an endocrine, lymphatic or metabolic condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.

<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (F) ON MUSCLE, SKELETAL, OR SKIN CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on or if surgery has been recommended in the last 6 months for this condition
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

<u>E. Endocrine, Lymphatic or Metabolic Conditions</u>			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
What type of endocrine, lymphatic or metabolic condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.				Year	Yes	No	Less than one year ago	1 to 3 years ago
133	Adrenal gland (Cushing's Disease, hyperaldosteronism) - hyper (over) production of adrenal hormones	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
134	Diabetes - Type I, with other health conditions (renal/kidney, neurological/nerves, eye including the retina, cardiac)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
135	Diabetes - Type I, without other health conditions	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
136	Diabetes - Type II, with other health conditions (renal/kidney, neurological/nerves, eye including the retina, cardiac)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

E. Endocrine, Lymphatic or Metabolic Conditions What type of endocrine, lymphatic or metabolic condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes		Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
137	Diabetes - Type II, without other health conditions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
138	Diabetic retinopathy (eye problems)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
139	Goiter - non-toxic (enlarged thyroid that does not produce an excess of thyroid hormones)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
140	Organic drug (illnesses caused by medications) or metabolic disorders (illnesses where the body cannot properly utilize proteins or carbohydrates)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
141	Parathyroid gland - hypo (under) functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
142	Thyroid gland - hyper (over) or hypo (under) functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

F. Muscle, Skeletal or Skin Conditions

Musculoskeletal conditions comprise over one hundred diseases and syndromes, which are usually progressive and associated with pain and involve your muscles, joints and bones. The largest organ in the body, the skin, is the first line of defense against dirt, germs and other foreign objects. Most skin disorders display symptoms on the surface of the skin.

Have you been diagnosed, treated and/or medicated for a muscle, skeletal or skin condition(s) in the last 10 years?	
Do not answer YES if you have or had a muscle, skeletal or skin condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (G) ON NON-PSYCHIATRIC CONDITIONS OF THE NERVOUS SYSTEM.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

F. Muscle, Skeletal or Skin Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes	No		Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
143	Bone & joint – infections (e.g., osteomyelitis or septic arthritis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
144	Burns less than 50% of one's body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
145	Bursitis (inflammation around the joint) & tendonitis (inflammation of the tendon not resulting in a loss of mobility or not resulting in a disability)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
146	Joint - major inflammation resulting in a loss of mobility or resulting in a disability (e.g., aseptic necrosis, polyarthritis, crystal arthropathies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
147	Joint degeneration, localized in one area (e.g., osteoarthritis or spondylolithiasis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
148	Joint derangement, other (e.g., dislocation, ligament and cartilage tears, herniated disk)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

F. Muscle, Skeletal or Skin Conditions What type of muscle, skeletal or skin condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes			Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
149	Major trauma (physical injury) other than bone break or dislocation (e.g., puncture, loss of blood supply to the limb)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
150	Orthopedic deformity (abnormal bone or joint structure) leading to poor growth for either (e.g., kyphosis, scoliosis)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
151	Osteoporosis	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
152	Rheumatoid Arthritis (RA) – adult	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
153	Rheumatoid Arthritis (RA) – juvenile	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
154	Skin – major bacterial infections (e.g., cellulitis or hidradenitis suppurativa), not including MRSA or Necrotizing fasciitis	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
155	Skin & subcutaneous (under the skin) tissue – inflammation (e.g., psoriasis, cellulitis, fasciitis, pemphigus, dermatomyositis)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
156	Spinal or back trauma (physical injury), including strains and sprains, that does not resolve within 3 months	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

G. Non-Psychiatric Conditions of the Nervous System

The nervous system is a complex, sophisticated system that regulates and coordinates body activities. Disorders of the nervous system may involve the following: vascular disorders (such as stroke), infections (such as meningitis), structural disorders (such as brain or spinal cord injury), functional disorders (such as headache, epilepsy) and degeneration (such as Parkinson's disease, multiple sclerosis and Alzheimer's disease) are all examples of these disorders or conditions.

Have you been diagnosed, treated and/or medicated for a non-psychiatric condition(s) of the nervous system in the last 10 years?	
Do not answer YES if you have or had non-psychiatric (non-mental health) condition(s) of the nervous system unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (H) ON PSYCHIATRIC (MENTAL HEALTH) CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

G. Non-Psychiatric Conditions of the Nervous System		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
What type of non-psychiatric condition(s) of the nervous system do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			Year	Yes	No	Less than one year ago	1 to 3 years ago
157	Alzheimer's disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
158	Brain abscess (infectious area)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
159	Central nervous system (brain and spinal cord) – diseases that are congenital, hereditary, genetic, or due to toxic substances or medications (e.g., spina bifida, meningomyelocele, hydrocephalus), not including Alzheimer's disease, ALS, Parkinson's disease, or MS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
160	Central nervous system (brain and spinal cord) - infection or inflammation (e.g., encephalitis, myelitis, but excluding meningitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
161	Cerebral Vascular Accident (CVA) - stroke, hemorrhagic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

G. Non-Psychiatric Conditions of the Nervous System What type of non-psychiatric condition(s) of the nervous system do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes			Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
162	Cerebral Vascular Accident (CVA) - stroke, ischemic (caused by a lack of blood to the brain most often due to a clot)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
163	Cranial nerves (affecting the head, face, eyes, tongue and/or throat including speech) - traumatic (physical injury) disorders	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
164	Cranial nerves (affecting the head, face, eyes, tongue and/or throat including speech) - inflammation (e.g., herpetic lesions to the face and/or eye, Bell's Palsy, trigeminal nerve disorders, facial nerve disorders and acoustic nerve disorders)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
165	Epilepsy (seizures)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
166	Meningitis (inflammation/infection of the lining of the brain and spinal cord)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
167	Migraine headache with pre-headache aura, dizziness, nausea, blurred vision lasting over 72 hours in adults, 48 hours in children	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
168	Migraine headache, common, i.e. without a pre-headache aura but may have vague pre-headache symptoms such as mood changes or fatigue	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
169	Non-cranial nerves, including carpal tunnel – inflammation (e.g., sciatica)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
170	Parkinson's disease	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

H. Psychiatric (Mental Health) Conditions

Mental illness is any disease or condition affecting the brain that influences the way a person thinks, feels, behaves and/or relates to others and to his or her surroundings. Although the symptoms of mental illness can vary from mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands.

Have you been diagnosed, treated and/or medicated for psychiatric (mental health) conditions in the last 10 years?	
Do not answer YES if you have or had a psychiatric (mental health) condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (I) ON REPRODUCTIVE CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

H. Psychiatric (Mental Health) Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
What type of psychiatric (mental health) condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
171	Alcohol dependence (chronic alcoholism), with a medical diagnosis of other organs being affected	<input type="radio"/>	Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
172	Alcohol dependence (chronic alcoholism), without a medical diagnosis of other organs being affected	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
173	Alcohol intoxication (poisoning) - drunkenness due to binge drinking and requiring medical attention	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
174	Anxiety, personality, somatoform (i.e., an illness where a physician cannot find an organic cause), or attention deficit (without hyperactivity) disorders or phobias (irrational fears)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
175	Attention Deficit with Hyperactivity Disorder (ADHD)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

H. Psychiatric (Mental Health) Conditions What type of psychiatric (mental health) condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes			Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
176	Autism – mild (i.e., able to attend school with limited assistance) or child psychoses	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
177	Cocaine, amphetamine, opioid or barbiturate dependence	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
178	Eating disorders (e.g., anorexia, bulimia)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
179	Mood disorders, bipolar, with psychosis	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
180	Mood disorders, bipolar, without psychosis	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
181	Mood disorders, depression, with psychosis	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
182	Mood disorders, depression, without psychosis	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

I. Reproductive Conditions

Humans have the potential to create offspring when an egg from a woman is fertilized by sperm from a man. Eggs (ova) are made in the ovaries, and sperm in the testicles. The ovaries and testicles (gonads) also make sex hormones. The female reproductive system is made up of the vagina, womb (uterus), fallopian tubes and ovaries. The male reproductive system is made up of the penis, the testicles, the epididymis, the vas deferens and the prostate gland. Problems with male and female sex organs result in pain, swelling, tissue build up, hormone fluctuations, sexual impotence, infertility, prostate problems and sexually transmitted infectious diseases.

Have you been diagnosed, treated and/or medicated for a reproductive condition(s) in the last 10 years?	
Do not answer YES if you have or had a reproductive condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (J) ON RESPIRATORY CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery was recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

I. Reproductive Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
What type of reproductive condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
183	Conditions (illnesses) associated with a woman's menstrual period (e.g., painful, infrequent, light, or heavy periods)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
184	Conditions (illnesses) that impact fertility or problems with the female reproductive system, not including menopause	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
185	Disorders (problems) with the male reproductive system (e.g., conditions that result in low sperm count, genetic disorders such as Klinefelter's syndrome, varicocele)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
186	Inflammation of female genital tract (ovary, uterus, cervix, vagina)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
187	Vaginal infections (e.g., repetitive monilial (yeast) infections at least 3 times per year, or bacterial vaginitis, not related to sexual contact)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

J. Respiratory Conditions

The respiratory system consists of the airways, the lungs, and the respiratory muscles that control the movement of air in and out of the body. Within the lungs, molecules of oxygen and carbon dioxide are exchanged between the air we breathe and the blood. Respiratory disease includes problems that obstruct or restrict breathing and include breathing problems from infection, the environment or other diseases.

Have you been diagnosed, treated and/or medicated for a respiratory condition(s) in the last 10 years?	
Do not answer YES if you have or had a respiratory condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (K) ON URINARY CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

J. Respiratory Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
What type of respiratory condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
188	Allergic rhinitis (nose irritation, hay fever)	<input type="radio"/>	Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
189	Asthma	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
190	Chronic bronchitis resulting in cough and mucous production lasting at least 3 months	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
191	Chronic Pulmonary Disease (lungs, bronchi, trachea) occupational and environmental in origin (e.g., Black Lung disease, asbestosis, silicosis)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
192	Emphysema (chronic obstructive pulmonary disease - COPD)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
193	Lung infections (e.g., pneumonia, whooping cough) – bacterial	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
194	Lung infections (e.g., pneumonia, aspergillosis) – fungal or viral	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

J. Respiratory Conditions What type of respiratory condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes		Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
195	Pulmonary congenital anomalies - lung, bronchi, trachea (windpipe) problems that developed prior to birth (e.g., congenital bronchiectasis, congenital cystic lung, agenesis of the lung (lung does not form) and congenital problems of the diaphragm)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
196	Tuberculosis (TB) - disseminated (infection spread to other body organs)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

K. Urinary Conditions

The body takes nutrients from food and converts them to energy. After the body has taken the food that it needs, waste products are left behind in the bowel and in the blood. The urinary system keeps the chemicals and water in balance by removing a type of waste, called urea, from the blood. Urinary conditions are comprised of problems with how the kidneys, ureters, bladder, and urethra function.

Have you been diagnosed, treated and/or medicated for a urinary condition(s) in the last 10 years?	
Do not answer YES if you have or had a urinary condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (L) ON OTHER CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

K. Urinary Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?			
What type of urinary condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.	Yes		Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
197	Genitourinary system (kidney, ureter, urinary bladder, urethra, prostate) - trauma (physical injury)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
198	Genitourinary system (ureter, urinary bladder, urethra, prostate), except kidney stones, not sexually transmitted, inflammation or infections	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
199	Kidney stones	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
200	Renal (kidney) inflammation – acute	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
201	Renal (kidney) inflammation – chronic	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

L. Other Conditions

Have you been diagnosed, treated and/or medicated for any of the following condition(s) in the last 10 years?	
Do not answer YES if you have or had any of these condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
<input type="radio"/> Yes	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.
<input type="radio"/> No	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (M) FOR WRITE-IN CONDITIONS.

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

L. Other Conditions		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
	What type of other condition(s) listed below do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.		Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
202	Autoimmune rheumatologic diseases (e.g., autoimmune connective diseases such as scleroderma, Sjogren's Syndrome, ankylosing spondylitis, or psoriatic arthritis), not including lupus or rheumatoid arthritis (RA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
203	Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
204	Chromosomal anomalies (e.g., Turner's Syndrome, Patau's Syndrome, Cri du Chat Syndrome, Velo-Cranio-Facial Syndrome (VCFS) and Prader-Willi Syndrome), not including Down's Syndrome or Fragile X Syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
205	Chronic sinusitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
206	Eye - external infections, except pink eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
207	Eye – internal infections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
208	Eye problems developed prior to birth, including cataracts, ptosis or drooping eye, congenital blindness that occurred prior to birth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
209	Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TABLE CONTINUED ON NEXT PAGE

L. Other Conditions What type of other condition(s) listed below do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
Yes			Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
210	Hearing disorders (decreased hearing, deafness), requiring treatment by a physician	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
211	Lupus with additional health problems including renal insufficiency or failure, memory or behavioral problems, pleurisy, heart attack, increased occurrence of infection, bone and tissue problems	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
212	Lupus, without complication	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
213	Macular (eye) degeneration	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
214	Major infectious diseases (e.g., malaria, Anthrax, leprosy, West Nile virus, herpes zoster, meningococemia), not including HIV, septicemia, or tuberculosis	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
215	Mental retardation	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
216	Morbid obesity or Body Mass Index (BMI) over 40, if known	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
217	Sexually transmitted diseases, localized or systemic (e.g., syphilis, gonorrhea, chlamydia, herpes, genital warts), not including HIV-AIDS	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
218	Visual disturbances – major (blindness, detached retina, retinitis pigmentosa)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

M. Write-in Conditions

Have you been diagnosed, treated and/or medicated for other medical conditions in the last 10 years not listed in any other tables above?	
Do not answer YES if you have or had other conditions unless a doctor or other licensed medical care provider told you that you have or had this condition.	
Yes <input type="radio"/>	IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW. WRITE-IN CONDITIONS WILL BE SCORED IF THAT CONDITION IS INCLUDED IN THE CURRENT SCORING SYSTEM.
No <input type="radio"/>	IF NO, PLEASE CONTINUE TO THE NEXT SECTION (N) ON HEALTH BEHAVIORS.

To fill out the table below follow these steps:

1. **First**, write in the type of condition you have or had in the first column of the table
2. **Second**, if you wrote in a condition, write the year of your diagnosis in the next column
3. **Third**, if you wrote in a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for that condition**
4. **Fourth**, if you wrote in a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

M. Write-In Conditions What type of other condition(s) do you or did you have in the last 10 years? Write in the condition(s) below.	What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition most recently operated on, treated or medicated?		
		Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
	Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

N. Health Behavior Questions

Please answer the following four questions. Your responses to these questions will not affect your score.

<p>1. What is your current smoking status?</p> <ul style="list-style-type: none"><input type="radio"/> Current smoker<input type="radio"/> Former smoker<input type="radio"/> I have never smoked	<p>2. During the past four weeks, how much bodily pain have you had?</p> <ul style="list-style-type: none"><input type="radio"/> No pain<input type="radio"/> Very mild pain<input type="radio"/> Mild pain<input type="radio"/> Moderate pain<input type="radio"/> Severe pain
<p>3. How confident are you that you can control and manage most of your health problems?</p> <ul style="list-style-type: none"><input type="radio"/> Very confident<input type="radio"/> Somewhat confident<input type="radio"/> Not very confident<input type="radio"/> I do not have any health problems	<p>4. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?</p> <ul style="list-style-type: none"><input type="radio"/> Not at all<input type="radio"/> Slightly<input type="radio"/> Moderately<input type="radio"/> Quite a bit<input type="radio"/> Extremely

WHEN YOU ARE DONE WITH THESE QUESTIONS PROCEED TO THE NEXT PAGE

SECTION III. SIGNATURE PAGE AND SCORES

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following:**

1. **All of the information I have given is true and complete.**
2. I understand that if I leave an answer blank to an individual condition it is the same as a “no” answer.
3. If I answered “no” to subsection (A), I have completed all remaining subsections, (B) through (N) of Section II, and indicated “yes” or “no” at the top of each subsection, (B) through (M).
4. I understand that if I omit or give false information I may lose my coverage, in which case I may have to pay for services paid under that coverage.
5. **I understand that if I intentionally give false information, in addition to losing my coverage, I may incur additional legal liability.**

IF YOU DO NOT SIGN AND DATE THIS QUESTIONNAIRE BELOW, IT WILL BE RETURNED TO YOU AND YOUR APPLICATION PROCESS WILL BE DELAYED.

Please print name, then sign and date in the space provided.

First Name M.I. Last Name

/ /

Signature

Date Signed

If you are signing on behalf of an underage child, check: Parent Legal Guardian

THANK YOU FOR COMPLETING THE STANDARD HEALTH QUESTIONNAIRE.

This questionnaire is updated at least every 18 months. In an effort to continually improve the questionnaire, we have included a brief survey on our website. If you would like to **provide feedback** on your experience filling out this questionnaire, please go to the following web address www.wship.org/SHQsurvey. This brief survey is optional and has no effect on your score.

FOR INSURANCE CARRIER USE ONLY. DO NOT MARK THIS SECTION.

Name of carrier

Date Reviewed

Reviewer ID

Member SSN (optional)

	<u>Condition #</u>	<u>Score</u>		<u>Condition #</u>	<u>Score</u>		<u>Condition #</u>	<u>Score</u>
1.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	5.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	9.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>
2.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	6.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	10.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>
3.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	7.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	11.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>
4.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	8.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	12.	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>

Total Score

Applicant Accepted Applicant Denied