Application for Individual Comprehensive Health Insurance

Mercy Health Plans
14528 S Outer 40, Ste. 300
Chesterfield, MO 63017-5743
314-214-8100 ▪ 1-800-830-1918

Applicant Information

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

NAME: First	Middle	Last		
ADDRESS: Street	City	State	Zip	County
Home Phone #: (including area code)	Work Phone #: (including area code)	E-mail Address		

General Member Information: Please fill out information below for any family members who are applying for coverage (attach other pages, if needed).

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

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

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

Do you know of any significant medical information relating to the applicant or any of his dependents that has not been reported on this form? (Does not include HIPAA applicants.) Yes ☐ No ☐

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

Agency Name: ______________________ Broker's Name: ______________________
Broker's Telephone # ______________________ Broker's Email: ______________________
Broker's Signature: ______________________ Date: ______________________

Notification: Broker Only ☐
Broker and Subscriber ☐

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

YOU MUST COMPLETE THIS SECTION – even if you are not currently applying for HIPAA coverage.

Mercy Health Plans has underwriting criteria that you may not meet because of your health conditions. If you do not qualify for one of our standard plans because of your health, you may still qualify for one of the plans that are available as a result of HIPAA (Health Insurance Portability and Accountability Act of 1996).

Individuals who qualify for and elect to enroll in a HIPAA plan are guaranteed acceptance without exclusions, waiting periods or denial of coverage for pre-existing conditions.

The premium for the HIPAA plan is higher than for non-HIPAA plans.

Are you applying for a HIPAA plan? Yes ☐ No ☐

	True	False
1) You and your covered dependents have had coverage for at least 18 months without a break in coverage of 63 days or more?	☐	☐
2) Your most recent coverage was through a group, church or government health plan (other than Medicare, Medicaid or the state health insurance pool).	☐	☐
3) You or your covered dependents are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.	☐	☐
4) Available COBRA or State Continuation coverage has been elected and exhausted as of the date this coverage becomes effective?	☐	☐
5) Your previous coverage was terminated due to fraud or nonpayment of premium. If this statement is true, explain circumstances: ____________________ ____________________	☐	☐

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

1) Type of coverage: ☐ Applicant only (Ages 19-65 yrs.) ☐ Child Only (Age 6 mos. – 18 yrs.) ☐ Applicant & spouse ☐ Applicant & unmarried children* ☐ Applicant, spouse & unmarried children*
* Unmarried dependent children up to age 25.

2) Effective date requested: ____/____/________
Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.

3) OPTIONAL RIDERS: Family Services Rider – Additional <u>$ 4.50 /month</u> ☐ Yes ☐ No

4) Select Plan Option: Choose ONLY ONE Plan option.
Note: Maternity benefits apply only to the applicant or applicant's spouse, and will not begin for one year.

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
☐ A	12 month	No	$1,000	$2,000	$15/$35	100/70%	$10/$40/$65
☐ B	12 month	No	$2,500	$5000	$15/$35	100/70%	$10/$40/$65
☐ C	12 month	No	$5,000	$10,000	$15/$35	100/70%	$10/$40/$65
☐ AA	12 month	Yes	$1,000	$2,000	$15/$35	100/70%	$10/$40/$65
☐ BB	12 month	Yes	$2,500	$5000	$15/$35	100/70%	$10/$40/$65
☐ CC	12 month	Yes	$5,000	$10,000	$15/$35	100/70%	$10/$40/$65
☐ D	12 month	No	$500	$1,000	$15/$35	80/60%	$10/$40/$65
☐ E	12 month	No	$1,000	$2,000	$15/$35	80/60%	$10/$40/$65
☐ F	12 month	No	$2,500	$5,000	$15/$35	80/60%	$10/$40/$65
☐ G	12 month	No	$5,000	$10,000	$15/$35	80/60%	$10/$40/$65
☐ DD	12 month	Yes	$500	$1,000	$15/$35	80/60%	$10/$40/$65
☐ EE	12 month	Yes	$1,000	$2,000	$15/$35	80/60%	$10/$40/$65
☐ FF	12 month	Yes	$2,500	$5,000	$15/$35	80/60%	$10/$40/$65
☐ GG	12 month	Yes	$5,000	$10,000	$15/$35	80/60%	$10/$40/$65

HIPAA Plans: The premium for the HIPAA plans is higher than for non-HIPAA plans.

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
☐ E	12 month	No	$1,000	$2,000	$15/$35	80/60%	$10/$40/$65
☐ G	12 month	No	$5,000	$10,000	$15/$35	80/60%	$10/$40/$65

Health History:
Complete your health history by answering "Yes" or "No" to the questions in the following section.
If you are only applying for the HIPAA plan, you do not need to fill out the Health History section of this application.

1) Have you or any family member(s) who are applying for coverage smoked or used other smokeless tobacco products within the last 12 months? Yes ☐ No ☐

2) Are you or any family member(s) who are applying for coverage currently pregnant? Yes ☐ No ☐

3) Do you or any family member(s) who are applying for coverage have any health conditions that a reasonably prudent person would anticipate requiring future medical treatment or surgery within the next 12 months? Yes ☐ No ☐

   If so, what are those health conditions, and what treatments are considered? (Attach other pages if needed)

   ____

   ____

4) In the last ten years have you or any family member(s) applying for coverage had any signs, symptoms, indications, diagnoses or treatment of any disease, disorder or injury, or had any test results that were abnormal? Yes ☐ No ☐

   If so, what are those disease states, injuries or abnormal test results? (Attach other pages if needed)

   ____

   ____

5) Are you or any family member(s) applying for coverage taking any drugs prescribed by a physician or any over the counter drugs? Yes ☐ No ☐

List below: 1) all prescription or over-the-counter drugs that are taken, 2) the person for whom each drug is prescribed, 3) the prescribing physician and 4) the conditions that the drugs are prescribed to treat (attach other pages, if needed). *It is important to note that if you are taking any prescribed medication, you should answer "Yes" to one or more of the questions relating to organ systems/diseases in number six (6) below.*

Name of Drug	Person Drug Prescribed For	Prescribing Physician:	Condition Drug Prescribed to Treat

6) Have you or any family member(s) applying for coverage currently have, or been diagnosed or treated for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases?

Check "Yes" or "No" for all conditions listed below as they apply for any covered family member. NOTE: If you answer "Yes" to any of these screening questions you must also answer the Secondary Questions related to those conditions attached to this form. Refer to page number listed in the Secondary Questions to the Application for Individual Health insurance.

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

** Please answer the Secondary Questions pertaining to these conditions for every "Yes" response.*

7) Primary physician name and phone number: ______________________________

Date of last physical exam: ____/____/________.

Statements of Understanding:
Please read all statements below. Each person, age 18 or over, to be covered on this policy will need to sign at the bottom of this form.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans.

2. I understand that I will receive either an acceptance or denial from MHP or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application

3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full.

4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.

5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical condition disclosed within this application will not be covered for up to 12 months after my effective date.

6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage will be rescinded in its entirety at MHP's discretion. **EXCEPTION: This does not apply to the HIPAA plans.**

7. I understand that I, or any of my covered family members, may need to obtain a physical examination at my own expense prior to acceptance for coverage, if such an examination has not been performed within the last two years.

8. I understand that I, or any of my covered family members, must notify Mercy Health Plans if we seek and receive medical attention from the time this application is completed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change. **EXCEPTION: This does not apply to the HIPAA plans.**

9. I understand that if I purchase maternity benefits, they apply only to my spouse or me and do not begin until we have been covered for 12 months under the plan that includes the maternity benefit. Maternity benefits are not available for our dependent children and do not apply to child only plans.

10. I understand and agree that Mercy Health Plans may obtain information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.

11. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.

Authorization to Use and Disclose Protected Health Information

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

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

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

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

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

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

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

	Signature:	**Printed Name:**	**Relationship to Applicant:**	**Date:**
Applicant				
Applicant’s Spouse				
Dependent Child 1				
Dependent Child 2				
Dependent Child 3				
Dependent Child 4				
Dependent Child 5				
Dependent Child 6				

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

Payment Information:

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

Please check your method of payment:

☐ **Automatic Bank Account Withdrawal**

☐ Checking account (attach voided check below)

☐ Savings Account

Account # ____

Routing #____

☐ **Credit Card**

☐ VISA ☐ MasterCard

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

____

Billing Address____

City_____________________________ **State**___________ **Zip** _________________

Telephone _______________________________

Credit Card Number: ____

Expiration Date (month/year): ______/_______

3-Digit Verification Code: ________ (See signature area on back of card)

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

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

_____________________________________ ____________________

Signature of Cardholder **Date**

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

. . . .

Attach Voided Check Here

SECONDARY QUESTIONS TO THE APPLICATION FOR INDIVIDUAL HEALTH INSURANCE

Have you ever been diagnosed with or sought treatment for any of these conditions?

YOU ONLY NEED TO ANSWER THE SECONDARY QUESTIONS THAT CORRESPOND TO THE SCREENING QUESTIONS ON THE APPLICATION

	YES	NO
1. Diabetes/Abnormal Blood Sugar	☐	☐

Which family member(s) has diabetes/pre-diabetes/hypoglycemia?

____

	YES	NO
Diabetes/Pre-diabetes?	☐	☐
Which type of diabetes has been diagnosed?		
Type I, Insulin Dependent	☐	☐

If Type I, # units of insulin per day?

☐ < 75 units ☐ > 100 units
☐ 75-100 units ☐ Don't know

	YES	NO
Type II, Non-Insulin dependent	☐	☐
Gestational	☐	☐
Other type/Don't know	☐	☐
Date initial diagnosis made (in MMYYYY)?	____/____	
Oral meds to control blood sugar?	☐	☐

Average glucose levels within last six months.

If fasting glucose levels

☐ 65-115 ☐ 116-175 ☐ >175

If random glucose levels

☐ <200 ☐ 201-250 ☐ >250

In addition, does patient have any of these conditions?	YES	NO
Diabetic eye complications	☐	☐
Peripheral neuropathy	☐	☐
High Blood Pressure	☐	☐
Coronary Artery Disease	☐	☐
Kidney Problems/Renal Failure	☐	☐
Hypoglycemia	☐	☐

	YES	NO
2. Endocrine System/Thyroid	☐	☐

Which family member(s) has endocrine system/thyroid condition?

____

	YES	NO
Hyperthyroidism/Hashimoto's Thyroiditis/Graves Disease - excess thyroid hormone	☐	☐

What kind of treatments have you had for this?

☐ Surgery ☐ Radioactive Iodine ☐ Other ________

	YES	NO
If surgery, date it was done (in MMYYYY)?	____/____	
Does medical/RX management control disease?	☐	☐
Hypothyroidism-low thyroid hormone	☐	☐
Toxic Thyroid Goiter-Plummer's Disease	☐	☐
When was diagnosis made (in MMYYYY)?	____/____	
Hyperparathyroidism	☐	☐
Did you have surgery for?	☐	☐
If NO, does medication control disease?	☐	☐
If YES,give date of surgery (in MMYYYY)?	____/____	

	YES	NO
Hyperaldosteronism (Cushing's Disease)	☐	☐
Is the cause of disease known?	☐	☐
If cause is known, describe condition, below		

____

____

____

	YES	NO
Date condition diagnosed (in MMYYYY)?	____/____	
Is the condition stable with treatment?	☐	☐
Addison's Disease (Chronic Adrenal Insufficiency)	☐	☐
Growth Hormone Deficiency	☐	☐
Other Thyroid/Endocrine system disorder	☐	☐
Please describe condition below		

____

____

	YES	NO
3. High Blood Pressure/Hypertension	☐	☐

Which family member(s) has high blood pressure?

____

THREE recent blood pressure readings in systolic/diastolic format

Systolic	Diastolic	Date Taken

	YES	NO
Readings taken while on meds for hypertension?	☐	☐
Diagnosed with malignant hypertension?	☐	☐

	YES	NO
4. Heart/Circ/Stroke/Aneurysm/Cholesterol	☐	☐

Which family member(s) has a heart/circulatory system condition?
____

	YES	NO
Aneurysm	☐	☐
Which type of aneurysm?		
☐ Abdominal/Descending Thoracic Aortic		
☐ Brain ☐ Femoral/Peripheral ☐ Other type		
Has aneurysm been operated on?	☐	☐
If yes, when was surgery (in MMYYYY)	☐	☐
If no, any further problems?	☐	☐
Is aneurysm inoperable?	☐	☐
Is aneurysm small and asymptomatic?	☐	☐
Hypercholesterolemia/Hyperlipidemia/High blood lipids/ High blood cholesterol	☐	☐
Secondary to another condition?	☐	☐
If yes, describe condition:______________________________ ______________________________		
What are cholesterol levels (in mg/dl)?		
☐ <=220 ☐ >220<=250 ☐ >250<=300 ☐ >300		
Are above levels while on cholesterol meds?	☐	☐
Anemia	☐	☐
What type of anemia do you have:		
☐ Unknown/Other ☐ Thalassemia Major		
☐ Pernicious ☐ Iron Deficiency		
☐ Sickle Cell ☐ Hemolytic Anemia		
If hemolytic, is cause of hemolysis known?	☐	☐
If hemolytic, have you had a spenectomy?	☐	☐
If yes, when was surgery (in MMYYYY)	____/_____	
Bleeding disorders/Hemophilia	☐	☐
What type of bleeding disorder has been diagnosed:		
☐ Christmas disease (Factor IX)		
☐ Hemophilia A (Factor VIII)		
☐ Oslo-Weber-Rendo disease		
☐ Other type of hemophilia		
If other, more than one bleeding episode a year?	☐	☐
Coronary Artery Disease/Heart Attack/ Myocardial Infarction	☐	☐
Have you had? ☐ Angioplasty ☐ Cardiac Bypass Surg ☐ Neither Angioplasty nor Bypass Surgery		
If performed, date procedure done?	____/_____	
If bypass surg, any cardiac problems since?	☐	☐
If subsequent problems, date resolved?	____/_____	
If no angioplasty/bypass, prior heart attack?	☐	☐
If history of heart attack, give date:	____/_____	
Congestive Heart Failure	☐	☐
Is the only treatment drug therapy?	☐	☐
Have you had any hospitalizations for?	☐	☐
Carotid Artery Occlusion	☐	☐
Is disease symptomatic and documented?	☐	☐
Have you had surgery to correct?	☐	☐
Cardiomegaly/Enlarged hear	☐	☐
Are you a heart transplant candidate?	☐	☐
Is the reason for the enlargement known?	☐	☐
If known, describe:______________________________ ______________________________		
Do you have any impairment from condition?	☐	☐

	YES	NO
Arrhythmias/Atrial Fibrillation	☐	☐
Episodes are: ☐ Single ☐ Multiple ☐ Chronic		
If multiple, are they controlled?	☐	☐
If YES, are they controlled: ☐ Drugs ☐ Surgical device		
Cause known for arrhythmias?	☐	☐
If cause known, describe:______________________________ ______________________________		
Conduction disturbances/Bundle Branch Blocks	☐	☐
Cause known for conduction disturbances?	☐	☐
If cause known, describe:______________________________ ______________________________		
Cardiac implantable device/pacemaker installed?	☐	☐
If yes, date of surgery?	____/_____	
What is the diagnosis:		
☐ Bundle Branch Block ☐ Sick Sinus Syndrome		
☐ AV Block ☐ Other		
☐ Complete 3rd Degree Block ☐ Don't Know		
Chest pain/Angina/Ischemic Heart Disease	☐	☐
Is clinical work up suggestive of coronary artery disease/blocked cardiac arteries?	☐	☐
If no, date of onset of symptoms?	____/_____	
Is cause known for chest pain?	☐	☐
If cause is known, describe:______________________________ ______________________________		
Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis	☐	☐
Do you currently have one of these conditions?	☐	☐
Have you had: ☐ Single episode ☐ Multiple episodes		
If single episode, date of onset of symptoms?	____/_____	
If multiple, date recovered from last episode?	____/_____	
Are you on anti-clotting RX?	☐	☐
Edema/Swelling of the extremities	☐	
Do you know what is causing swelling	☐	☐
If yes, describe:______________________________ ______________________________		
Cardiac Valve disorders/Heart Murmur/Mitral Valve Prolapse/ Mitral Regurgitation/Mitral Stenosis	☐	☐
Has the patient had surgery for condition?	☐	☐
If yes, was the valve: ☐ Repaired ☐ Replaced		
If yes, date of surgery:	____/_____	
If no, is the patient symptomatic?	☐	☐
Heart Transplant	☐	☐
Have you had a heart transplant?	☐	☐
If yes, date of surgery:	____/_____	
Are you on the waiting list for a transplant?	☐	☐
Cardiomyopathy	☐	☐
Are you on the waiting list for heart transplant?	☐	☐
Do you know what is causing cardiomyopathy?	☐	☐
If yes, describe:______________________________ ______________________________		

4. Heart/Circ/Stroke/Aneurysm/Cholesterol (Continued)

	YES	NO
Peripheral Vascular Disease/Claudication	☐	☐
Is diagnosis? ☐ Reynaud's Disease ☐ Buerger's Disease ☐ Neither Reynaud's or Buerger's		
If Reynaud's, has sympathectomy been done?	☐	☐
If Reynaud's, is condition rapidly progressing?	☐	☐
If Buerger's, date symptoms presented?	____/_____	
If Buerger's, any incidences of gangrene?	☐	☐
If neither, date diagnosis made?	____/_____	
If neither, any amputations?	☐	☐
If neither, more than one hospitalization for?	☐	☐

	YES	NO
Cerebral Vascular Accident (CVA)/Stroke/ Transient Ischemic Attack (TIA)	☐	☐
Was diagnosis CVA or TIA? ☐ CVA ☐ TIA		
Give date symptoms present themselves:	____/_____	
Any residual impairment?	☐	☐
Pericarditis	☐	☐
Is diagnosis restrictive pericarditis?	☐	☐
If no, was there only a single episode?	☐	☐
If no, was there any residual cardiac damage?	☐	☐
If no, give date symptoms presented?	____/_____	
If yes, did the patient have surgery?	☐	☐
If surgery, give date of surgery:	____/_____	
Other disease of the heart or circulatory system	☐	☐
Please describe condition:__________________________		

5. Respiratory/Lung Disorder/Asthma/TB

	YES	NO
5. Respiratory/Lung Disorder/Asthma/TB	☐	☐
Which family member(s) has a respiratory system condition? ______________________________		
Allergies/Asthma	☐	☐
Does the patient have: ☐ Asthma & Allergies ☐ Allergies Only ☐ Asthma Only		
If allergies, are you on desensitization shots?	☐	☐
If asthma, are attacks occasional or frequent? ☐ Occasional ☐ Frequent		
If asthma, any hospitalizations for?	☐	☐
If asthma, nebulizer used for acute episodes?	☐	☐
If asthma, are you taking corticosteroids?	☐	☐
Is asthma under control with medications?	☐	☐
Is the shortness of breath exercise induced?	☐	☐
Bronchitis	☐	☐
In last two years number of hospitalizations for bronchitis? ☐ not at all ☐ one time ☐ > than once		
Chronic Obstructive Lung Disease (COPD)/Emphysema	☐	☐
Have there been any hospitalizations for?	☐	☐
If yes, was there more than one hospitalization?	☐	☐
Sinusitis/Sinus Infection	☐	☐
Is the condition chronic?	☐	☐
Tuberculosis	☐	☐
Check one: ☐ Currently have ☐ Recovered from		

	YES	NO
How would you characterize symptoms? ☐ Mild ☐ Moderate ☐ Severe		
Pulmonary Embolism/Pulmonary Infarction	☐	☐
Is it known what caused embolism/infarction?	☐	☐
Please describe condition:____________________________		
Single episode of symptoms?	☐	☐
Does patient have phlebitis-blood clots in legs?	☐	☐
When did symptoms last occur (in MMYYYY)?	____/_____	
Is patient continuing anticoagulant drug treatment?	☐	☐
Has the patient fully recovered?	☐	☐
Dyspnea/Shortness of Breath	☐	☐
Any underlying condition causing this?	☐	☐
Please describe underlying condition:___________________		
Is the shortness of breath exercise induced?	☐	☐
If yes, how would you characterize symptoms? ☐ Mild ☐ Moderate ☐ Severe		
Other respiratory condition	☐	☐
Please describe other condition:______________________		
Are you a recipient or candidate for a transplant?	☐	☐

6. Ear/Eye/Nose/Throat/Skin

	YES	NO
Which family member(s) has an EENT or skin condition? ______________________		
Middle ear infections/tubes in ears/Otitis Media	☐	☐
Are infections chronic?	☐	☐
Has there been more than one infection?	☐	☐
Are tubes present in ear canals?	☐	☐
Date of most recent episode (in MMYYYY)?	____/_____	
Cleft Palate	☐	☐
Has there been surgery for the condition?	☐	☐
If yes, when was surgery (in MMYYYY)?	____/_____	
If yes, is further surgery needed?	☐	☐
Cataracts	☐	☐
Both eyes?	☐	☐
Have you had surgery on?	☐	☐
If YES, date it was done (in MMYYYY)?	____/_____	
Glaucoma	☐	☐
If yes, provide current ocular pressure	__________	

	YES	NO
Psoriasis	☐	☐
Episodes are: ☐ Mild ☐ Severe		
Cellulitis-skin infection	☐	☐
More than one episode?	☐	☐
Are the episodes severe?	☐	☐
When was since last episode (in MMYYYY)?	____/_____	
Tonsillitis	☐	☐
Has the patient had surgery for?	☐	☐
Single episode of symptoms?	☐	☐
Date of last episode of symptoms (in MMYYYY)?	____/_____	
Sinusitis/Sinus Infection	☐	☐
Is condition chronic?	☐	☐
How many infections do you have a year?	__________	
Other Ear/Eye/Nose/Throat or Skin condition	☐	☐
Any hearing impairment or implant?	☐	☐
Please describe: ______________________		

7. Digestive/Intestinal/Liver Disorder

	YES	NO
Which family member(s) has a digestive system condition? ______________________		
GERD/Gastroesophageal Reflux Disease/Acid Reflux	☐	☐
Did symptoms abate/improve with drug therapy?	☐	☐
Are drugs you're taking prescribed by physician?	☐	☐
Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers	☐	☐
Have you had surgery for condition?	☐	☐
If yes - Any recurrence since surgery?	☐	☐
If yes - What type of surgery was done?		
☐ Subtotal gastrectomy ☐ Total gastrectomy		
☐ Other type of surgery		
If yes - When was surgery (in MMYYYY)?	____/_____	
If yes - Diagnosis of dumping syndrome?	☐	☐
If no - Any episodes of obstruction, any hospitalizations, or any hemorrhages?	☐	☐
If no - Date last episode of symptoms:	____/_____	
If no - More than one episode of symptoms?	☐	☐
Crohn's Disease/Inflammatory Bowel Disease	☐	☐
Have you had surgery for condition?	☐	☐
If yes - What kind of surgery was done?		
☐ Partial bowel resection ☐ Total bowel resection		
If partial - Date last episode of symptoms?	____/_____	
If total - Date surgery done?	____/_____	
If no surgery done - How many episodes of symptoms?		
☐ Single ☐ Multiple		
If single-Does diet & meds control symptoms?	☐	☐
If yes - Date of last episode of symptoms?	____/_____	
If no - When was last episode of symptoms?	____/_____	
If multiple - Date last episode of symptoms?	____/_____	
Gastrointestinal Bleeding	☐	☐
When was last bleeding episode (in MMYYYY)?	☐	☐
Are you currently under treatment?	☐	☐
Diverticulitis/Diverticulosis	☐	☐
Do you currently have symptoms from this?	☐	☐
Have you had surgery for?	☐	☐
If yes - Did patient get colostomy?	☐	☐
If yes - Which kind? ☐ permanent ☐ temporary		
All affected portion with diverticula removed?	☐	☐
If yes - Date surgery was done?	____/_____	
If all affected portion not removed - Date of last treatment?	____/_____	
If no surgery - Single episode of symptoms?	☐	☐
If yes - Date of episode (in MMYYYY)?	____/_____	
If no - Date last episode of symptoms?	____/_____	

	YES	NO
If Alcoholic Hepatitis - Do you currently have?	☐	☐
If no - How long since recovery?	____/_____	
If Alcoholic Hepatitis - Any alcohol consumption?	☐	☐
If Alcoholic Hepatitis - Normal liver function tests?	☐	☐
Gall Bladder Disease/Cholelithiasis/Cholecystitis	☐	☐
Any stones in Gall Bladder or Common Bile Duct?	☐	☐
Was it a single attack of symptoms?	☐	☐
Has the gall bladder been removed?	☐	☐
If yes - Date surgery done?	____/_____	
If no - Date of last attack of symptoms?	____/_____	
Jaundice or hepatitis in the last 6 months?	☐	☐
Hernia	☐	☐
Inguinal, Scrotal or Femoral hernia?	☐	☐
Has it been operated on?	☐	☐
If no, any symptoms from?	☐	☐
If unoperated and symptomatic, are symptoms managed by medicine?	☐	☐
Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis	☐	☐
☐ Currently under treatment		
☐ Single Attack in the past		
☐ Multiple Attacks in the past		
If multiple date of last episode of symptoms:	____/_____	
Colon Polyps/Rectal Polyps	☐	☐
Benign?	☐	☐
Recurrent?	☐	☐
Have you had surgery on?	☐	☐
Pancreatitis	☐	☐
Is condition chronic or acute?	☐	☐
Any history of alcohol abuse?	☐	☐
Any subsequent liver disease?	☐	☐
Single episode of pancreatitis?	☐	☐
Does patient currently have?	☐	☐
If no, date of last episode of symptoms:	____/_____	
Ulcerative Colitis/Chronic Inflammation of Colon	☐	☐
Single or multiple episodes?	☐	☐
Have you had surgery for condition?	☐	☐
If yes - Does patient have permanent ostomy?	☐	☐
If yes - date surgery done (in MMYYYY)?	____/_____	
If yes - Is patient on prescription medications?	☐	☐
If no - Is condition under control?	☐	☐
If no - Is patient taking steroid medication?	☐	☐
If no - date last episode of symptoms:	____/_____	

7. Digestive/Liver Disorder (Continued)

	YES	NO
7. Digestive/Liver Disorder (Continued)	☐	☐
Cirrhosis of the Liver/Hepatitis/Liver Disease		
Which type of liver disease has been diagnosed?	☐	☐
☐ Cirrhosis ☐ Hepatitis C		
☐ Hepatitis A ☐ Alcoholic Hepatitis		
☐ Hepatitis B ☐ Chronic Hepatitis		
If Hepatitis A - Normal liver function tests?	☐	☐
If Hepatitis B - Normal liver function tests?	☐	☐
If Hepatitis C - Normal liver function tests?	☐	☐
If Hepatitis C - Taking Interferon by injection?	☐	☐
Other digestive/intestinal disorder	☐	☐
Please describe:______________________________		

____

____

8. Reproductive Disorder/Prostate/STD

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

____

9. Urinary Tract/Kidney or Renal Disease

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

____

YES NO

10. Nervous System/Brain Disorder/Headache

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

____

Headaches/Migraines/Cluster Headaches

Characterization of severity & frequency of headaches (pick one)

- Mild, less than 5/year
- Severe, > 10/year
- Moderate, 5 - 10/year
- Recent onset of severe HA

Multiple Sclerosis

Recently diagnosed?

Polio

Do you: currently have / recovered from

If recovered from, are you wheelchair confined?

If recovered from, do you require cane, crutch or brace rather than a wheelchair?

Head Injury/Concussion

Was there a loss of consciousness?

If yes, how long was loss of consciousness?

- < 1 hour
- < 1 day
- more than 1 day

If < 1 hour-Any residual problems post recovery?

If < 1 day – give date of recovery: ____/_____

If < 1 day–Any residual problems post recovery?

Encephalitis/Encephalomyelitis

Currently have?

If no, any residual complications post recovery?

If no, how long since recovery (in MMYYYY)? ____/_____

Alzheimer's Disease/Senility/Dementia

How much independence does individual have?

- Total independence
- Requires some assistance with self care
- Totally dependent for self care

Heat Exhaustion/Heat Stroke

Which diagnosis? Heat Exhaustion / Heat Stroke

Single episode?

If no, date of last episode: ____/_____

YES NO

Hydrocephalus

Has the individual had surgery to correct?

If yes, any complications/ other neurological problems post-op?

Narcolepsy

Is condition under control with medication?

When was diagnosis made (in MMYYYY)? ____/_____

Neurofibromatosis

Is disease progressing?

If no, are symptoms mild?

Neuroma/Abnormal Nerve Growth

Is growth benign?

Has the patient been operated on?

If yes, when was surgery (in MMYYYY)? ____/_____

If no, when was recovery (in MMYYYY)? ____/_____

Is the diagnosis Morton's Neuroma?

ALS/Amyotrophic Lateral Sclerosis/ Lou Gehrig's Disease

Autism

Cerebral Palsy

Paralysis/Hemiplegia/Paraplegia

Huntington's Chorea

Parkinson's Disease

Spina Bifida

Viral Meningitis

Bacterial Meningitis

Creutzfeldt-Jakob Disease

Muscular Dystrophy

Motor Neuron Disease

Myasthenia Gravis

Neuralgia/Neuritis

Other disorder of the nervous system

Please describe:________________________________

____

YES NO

11. Epilepsy/Seizure Disorder

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

____

Seizure Disorder

Do you know what type of seizure has been diagnosed?

If yes, what is seizure type?

- Febrile
- Petit Mal
- Jacksonian
- Grand Mal
- Focal

Is another disease condition causing seizures?

If yes, please describe condition:______________________

____

YES NO

Are seizures increasing in frequency?

Is patient taking medications?

If yes, are seizures controlled by medication?

When was the last seizure (in MMYYYY)? ____/_____

Other seizure disorder

Please describe condition:__________________________

____

YES NO

12. Mental/Psychiatric Condition/Depression

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

____

Affective Disorders

What is diagnosis (pick one below)?

- Obsessive Compulsive Disorder (OCD)
- Panic Disorder
- Agoraphobia
- Anxiety Disorder
- Neuroses

Is treatment effective?

If yes, date treatment become effective? ____/_____

What is characterization of severity of symptoms?

- Mild
- Moderate
- Serve

Schizophrenia/Paranoia

YES NO

Major Depression/Bipolar Disorder

When was diagnosis made (in MMYYYY)? ____/_____

Eating Disorder/Bulimia/Anorexia

Do you currently have an eating disorder?

When was recovery (in MMYYYY)? ____/_____

Attention Deficit Disorder/ADD/ADHD

What is characterization of severity of symptoms?

- Mild
- Moderate
- Serve

Are symptoms controlled by medication?

Situational Depression/Mild Depression/Anxiety

Is only current treatment prescription medication?

Other mental health/psychiatric disorder

Please describe:________________________________

____

13. Drug or Alcohol Abuse — YES ☐ NO ☐

Which family member(s) has history of drugs or alcohol abuse?

____

What is patient dependent on?

☐ Alcohol ☐ Marijuana

☐ Drugs besides marijuana and alcohol

	YES	NO
Is the patient currently using?	☐	☐
If not currently using, when did the patient last use drugs/alcohol (in MMYYYY)?	____/_____	

14. Back or Neck Disorder — YES ☐ NO ☐

Which family member(s) has a back or neck condition?

____

	YES	NO
Cervical (Neck) or Thoracic (Mid Back) or Lumbar (Low Back)		
Disc Herniation or Protrusion	☐	☐
Are you under current treatment for?	☐	☐
Have you had surgery for condition?	☐	☐
If yes, any subsequent problems post-op?	☐	☐
If yes, date of surgery (in MMYYYY)?	____/_____	
If no surgery was done, have you recovered?	☐	☐
If you have recovered, date of recovery?	____/_____	
Are you totally disabled from condition?	☐	☐
Low Back Pain	☐	☐
Are you under current treatment for?	☐	☐
If not in current treatment, date of last episode?	____/_____	
Spinal Fractures	☐	☐
Any lingering neurological defects?	☐	☐
Was fracture a compression fracture?	☐	☐
When was last treatment (in MMYYYY)?	____/_____	
Spinal Stenosis	☐	☐
Have you had surgery for condition?	☐	☐
If Yes, give date of surgery:	____/_____	

	YES	NO
Ankylosing Spondylitis/Spondylolisthesis	☐	☐
Have you had surgery for condition?	☐	☐
If no, is condition symptomatic, requiring treatment?	☐	☐
Low Back Strain/Whiplash/Muscle Spasm	☐	☐
Are you under current treatment for?	☐	☐
Sciatica/Radiculitis/Radiating pain to legs or arms	☐	☐
Does patient have any neurological defects?	☐	☐
Is patient currently under treatment for?	☐	☐
Are episodes recurrent?	☐	☐
When was last episode (in MMYYYY)?	____/_____	
Spinal deformities/Scoliosis/Lordosis	☐	☐
Has patient had surgery for condition?	☐	☐
If surgery, any continuing problems post-op?	☐	☐
If surgery was done, date of surgery?	____/_____	
If no surgery, are you currently under treatment?	☐	☐
If you are currently under treatment, is condition? ☐ Mild or moderate ☐ Severe		
If no current treatment, date of last treatment?	____/______	
Spina Bifida/Myelocele	☐	☐
Has patient had surgery for condition?	☐	☐
If Yes, any residual neurological defects?	☐	☐
Other back/neck disorder	☐	☐

Please describe:_________________________________

____

15. Arthritis/Bone/Joint Disorder — YES ☐ NO ☐

Which family member(s) has bone/joint disease/disorder/arthritis?

____

	YES	NO
Arthritis	☐	☐

Kind of arthritis do you have?

☐ Osteoarthritis
☐ Degenerative ☐ Chronic proliferative
☐ Hypertrophic ☐ Arthritis deformans
☐ Senile ☐ Psoriatic
☐ Juvenile Rheumatoid ☐ Chondrocalcinosis
☐ Adult Rheumatoid ☐ Septic
☐ Atrophic ☐ Acute Infectious

	YES	NO
Is condition asymptomatic?	☐	☐
If symptomatic, date of first onset of symptoms:	____/_____	
Is more than one joint affected?	☐	☐
If no, is the joint a hip or knee?	☐	☐
Have you had a hip/knee replacement?	☐	☐
If you had surgery, date it was done:	____/_____	

Characterization of disease progression/degree of disability

☐ Mild, Minimal ☐ Moderate to Severe

	YES	NO
Is there a joint infection?	☐	☐
If yes, any bony involvement with infection?	☐	☐
If yes, is patient being currently treated?	☐	☐
If no, when was treatment completed:	____/_____	
Osteomyelitis/Bone Infection/Bone Abscess	☐	☐
Was there only a single episode?	☐	☐
Involved joint/bone was: ☐ Major joint/bone ☐ Minor joint/bone		
Under current treatment for?	☐	☐
If no, date treatment completed:	____/_____	
Bursitis/Tennis Elbow/Tendonitis/Synovitis	☐	☐
Was there only a single episode of symptoms?	☐	☐
Under current treatment for?	☐	☐

	YES	NO
Carpal Tunnel Syndrome	☐	☐
Has the patient had surgery for?	☐	☐
Paget's disease	☐	☐
Do you have a single affected area?	☐	☐
Was the disease an incidental finding?	☐	☐
Ligament tears/Torn Meniscus/Osteochondritis	☐	☐
Has the patient had surgery for?	☐	☐
If surgery, date of surgery:	____/_____	
Bone dislocation	☐	☐

Was the dislocation (choose one, below)?

☐ Congenital hip ☐ Patella (kneecap)
☐ Shoulder ☐ Knee (not kneecap)
☐ Hip-traumatic ☐ Other joint-traumatic

	YES	NO
Was there a single episode of symptoms?	☐	☐
Does the patient currently have?	☐	☐
Has the patient had surgery on?	☐	☐

Dislocation was:

☐ Unilateral/one sided ☐ Bilateral/both sides

	YES	NO
Bone fracture	☐	☐
Has treatment been completed?	☐	☐
Has the patient had surgery on?	☐	☐

Was the fracture? ☐ Union ☐ Non-Union

Was the fracture of?

☐ Leg/hip/foot ☐ Arm/hand/shoulder ☐ Other bone

	YES	NO
Rotator cuff tear	☐	☐
Has the patient had surgery on?	☐	☐
If yes, date of surgery:	____/_____	
Date of original injury:	____/_____	

15. Arthritis/Bone/Joint Disorder (Continued)

	YES	NO
Osteoporosis	☐	☐
Is underlying cause known for condition?	☐	☐
If yes, please describe cause for condition below: ____________________		
Any symptoms from?	☐	☐
Any subsequent fractures?	☐	☐
Does the patient take steroids for condition?	☐	☐
Gout/Gouty Arthritis/Hyperuricemia	☐	☐
Characterization of number of attacks? ☐ Few ☐ Frequent		
Are attacks well controlled by medication/diet?	☐	☐
Other bone/joint disorder	☐	☐
Please describe disorder: ____________________		

16. Muscular Disorder/Lupus

	YES	NO
16. Muscular Disorder/Lupus	☐	☐
Which family member(s) has muscular/connective tissue condition? ____________________		
Collagen diseases:Scleroderma/Ehlers-Danlos Syndrome/Mixed Connective Tissue disease/ Necrotizing Angiitis	☐	☐
Lupus Erythematosus	☐	☐
Fibromyalgia/Myitis/Myositis	☐	☐
Currently being treated?	☐	☐
If no current treatment, date of recovery:	____/_____	
Recurrent episodes?	☐	☐
Ligament tears/Meniscus tears/Osteochondritis Dessicans/Chondromalacia	☐	☐
Have you had surgery for condition?	☐	☐
If surgery, when was it done (in MMYYYY)?	____/______	
Muscle tissue abscess	☐	☐
Cause of abscess known? ☐ Trauma ☐ Disease ☐ Unknown		
Currently being treated?	☐	☐
If no current treatment, date treatment completed?	____/___	
Polymyositis/Neuromyositis/Dermatomyositis	☐	☐
Other Muscular/Connective Tissue disorder	☐	☐
Please describe: ____________________		

17. Cancer/Tumors/Cysts

	YES	NO
17. Cancer/Tumors/Cysts	☐	☐
Which family member(s) has a tumor, cancer or cyst? ____________________		
Cyst?	☐	☐
Please describe: ____________________		
Has the cyst been removed?	☐	☐
Cancer or Tumor?	☐	☐
Breast Cancer	☐	☐
Is the cancer recurrent?	☐	☐
If YES, have you had bone marrow transplant?	☐	☐
If YES, are you bone marrow transplant candidate?	☐	☐
Was the treatment surgery alone?	☐	☐
Is patient under current treatment?	☐	☐
If NO, date treatment completed:	____/_____	
Is the cancer metastatic?	☐	☐
Is patient under hospice care?	☐	☐
Lipoma/Adipose Tumor	☐	☐
Was tumor confirmed benign by biopsy?	☐	☐
Has the tumor been removed?	☐	☐

What was stage of tumor?

☐ Stage I ☐ Stage IIA ☐ Stage IIB
☐ Stage IIIA ☐ Stage IIIB ☐ Stage IV

YES NO

17. Cancer/Tumors/Cysts (Continued)

Basal Cell/Squamous Cell Skin Cancer ☐ ☐
Was tumor? ☐ Basal Cell ☐ Squamous Cell
Was tumor localized, & no lymph node involvement? ☐ ☐
Has there been any recurrence? ☐ ☐
Is patient under current treatment? ☐ ☐
What kind of treatment was done (choose one of following)?
☐ Mohs Micrographic surgery ☐ Radiation therapy
☐ Simple excision ☐ Carbon dioxide laser
☐ Electrodessication/curettage ☐ Topical fluorouracil
☐ Cryosurgery ☐ All others
If no current treatment, date treatment completed:____/_____

Ovarian Cancer ☐ ☐
What was stage of the tumor?
☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
Is patient under current treatment? ☐ ☐
If no current treatment, date treatment completed:____/_____
Is the cancer recurrent? ☐ ☐
Has patient had a bone marrow transplant? ☐ ☐
Is patient a bone marrow transplant candidate? ☐ ☐
Is the cancer metastatic? ☐ ☐
Is patient under hospice care? ☐ ☐

Prostate Cancer ☐ ☐
Is the cancer recurrent? ☐ ☐
Has cancer spread to other organs/organ systems? ☐ ☐
Is patient under current treatment? ☐ ☐
If no current treatment, date treatment completed:____/_____
What was stage of the tumor?
☐ Stage A ☐ Stage B ☐ Stage C ☐ Stage D
Did patient have only surgery or surgery with other treatments?
☐ Surgery alone ☐ Surgery & other treatments
Any post-surgical complications? ☐ ☐
Is the cancer metastatic? ☐ ☐
Is patient under hospice care? ☐ ☐

Cervical Cancer ☐ ☐
Is the cancer recurrent? ☐ ☐
What was stage of the tumor?
☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
Was hysterectomy only done and/or radiation treatments?
☐ Surgery alone ☐ Surgery & Radiation ☐ Radiation alone
Is patient under current treatment? ☐ ☐
If no current treatment, date treatment completed:____/_____
Is patient under hospice care? ☐ ☐

Colon/Rectal Cancer ☐ ☐
Is the cancer recurrent? ☐ ☐
What was stage of the tumor?
☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
Was treatment surgery alone, or surgery and/or other treatments?
☐ Surgery alone ☐ Surgery & other treatments
Is patient under current treatment? ☐ ☐
If no current treatment, date treatment completed: ____/____

YES NO

Colon/Rectal Cancer (continued)
Is cancer in remission? ☐ ☐
Is the cancer metastatic? ☐ ☐
Is patient under hospice care? ☐ ☐

Leukemia/Chronic Lymphocytic Leukemia (CLL)/Acute Lymphocytic Leukemia (ALL)/Chronic Myelogenous Leukemia (CML)/Acute Myeloid Leukemia (AML)/Acute Non Lymphocytic Leukemia (ANLL) ☐ ☐
Do you know kind of Leukemia diagnosed(choose one below)
☐ CLL ☐ ALL ☐ CML ☐ AML ☐ ANLL
Date leukemia was diagnosed: ____/_____
What was stage of the tumor?
☐ Stage 0 ☐ Stage I ☐ Stage II
☐ Stage III ☐ Stage IV ☐ Refractory
Is patient under current treatment? ☐ ☐
If no current treatment, date treatment completed:____/____
Has the patient had a bone marrow transplant? ☐ ☐
If no, is bone marrow transplant considered? ☐ ☐
Has the patient had chemotherapy? ☐ ☐
Has the patient had radiation? ☐ ☐
Is the cancer in remission? ☐ ☐
Date cancer went into remission: ____/_____
Is patient receiving post-remission chemotherapy? ☐ ☐
Was treatment?
☐ Radiation ☐ Chemotherapy ☐ Chemotherapy & Radiation
Has the patient had a relapse or recurrence? ☐ ☐
Is patient under hospice care? ☐ ☐

Lymphoma/Hodgkin's disease/Non-Hodgkin's Lymphoma
Lymphoma type?
☐ Hodgkin's ☐ Other type Lymphoma
☐ Non-Hodgkin's ☐ Don't Know
What was stage of the tumor?
☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
Is patient under current treatment? ☐ ☐
If no current treatment, date treatment completed:____/____
Is cancer in remission? ☐ ☐
Is cancer recurrent? ☐ ☐
Is patient under hospice care? ☐ ☐

Melanoma ☐ ☐
What was stage of the tumor?
☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
Is patient under current treatment? ☐ ☐
If no current treatment, date treatment completed:____/____
Is cancer in remission? ☐ ☐
Is cancer recurrent? ☐ ☐
Was treatment surgical excision alone? ☐ ☐
Was there only a single lesion? ☐ ☐
Was skin grafting necessary? ☐ ☐
Is patient under hospice care? ☐ ☐

	YES	NO		YES	NO
17. Cancer/Tumors/Cysts (Continued)					
Lung Cancer	☐	☐	Is cancer recurrent?	☐	☐
What kind of Lung cancer was diagnosed?	☐	☐	Is cancer in remission?	☐	☐
			Is patient under current treatment?	☐	☐

Pick from:
- ☐ Squamous cell
- ☐ Large or Giant cell
- ☐ Oat Cell
- ☐ Adeno CA
- ☐ Intermediate Cell
- ☐ Adenosquamous
- ☐ Mixed Cell
- ☐ Non Small Cell
- ☐ Small Cell

What was stage of the tumor?
- ☐ Stage 0
- ☐ Stage IV
- ☐ Stage I
- ☐ Limited
- ☐ Stage II
- ☐ Extensive
- ☐ Stage III

If no current treatment, date treatment completed:____/____

What was treatment (pick one below)?
- ☐ Surgery
- ☐ Other Chemotherapy, not Taxol
- ☐ Radiation
- ☐ Chemotherapy and Radiation
- ☐ Taxol Chemotherapy
- ☐ Untreated

	YES	NO
Is patient under hospice care?	☐	☐
Other type of cancer/tumor:	☐	☐

Please describe condition below:_____________________

____

	YES	NO		YES	NO
18. HIV/AIDS/ARC Autoimmune Disease	☐	☐			

Which family member(s) has HIV, AIDS or autoimmune disease?

____

	YES	NO
HIV (human immunovirus)	☐	☐
AIDS (acquired immune deficiency syndrome)	☐	☐
ARC (AIDS related complex)	☐	☐
Autoimmune disease	☐	☐

Please describe condition:_________________________

	YES	NO		YES	NO
19. Any other Illness, Disease or Injury	☐	☐			

Which family member(s) has another type of disease condition, disorder or injury?

____

	YES	NO
Other Disease/Disease Condition/Disorder/Injury not previously described	☐	☐

Please describe other condition:_______________________

____

____

____

____

____

____

	YES	NO
As a result of injury/illness have you had:	☐	☐
Bone or skin Graft(s)?	☐	☐
Joint replacement?	☐	☐
Loss of limb?	☐	☐
Loss or surgical removal of organ/limb?	☐	☐

If yes, please describe:____________________________

____

____