



## Standard Health Questionnaire for Washington State (Recertification Effective October 1, 2006)

### PART I

#### **A. EXCEPTIONS – DO NOT FILL OUT THIS HEALTH QUESTIONNAIRE IF ANY OF THE FOLLOWING APPLY:**

1. You have Medicare benefits.
2. When a newborn, a child placed for adoption, or a newly adopted child regardless of age is being added to a parent's existing policy, a health questionnaire does not need to be filled out for the child as long as the addition of the child is made within 60 days of birth, placement, or adoption.
3. You are applying for medical insurance because you have used up all the available time on your "COBRA" coverage. In order for this exception to apply, you must submit your application to the new insurance carrier within 90 days from the date that COBRA coverage ended.
4. Your former employer, who provided you with health coverage, has gone out of business while you were on "COBRA" coverage, and you are applying for individual coverage with a new insurance carrier within 90 days from the date that coverage ended.
5. You are applying for coverage with a new carrier because you have moved from one part of Washington State to another, and the insurance carrier that you had does not offer medical coverage where you live now. In order for this exception to apply, you must submit your new application to the new insurance carrier within 90 days from the time that you moved.
6. You are applying for coverage with a new insurance carrier because your doctor or other health care provider has stopped being a part of the provider network on your current individual medical plan. In order for this exception to apply,
  - a. Your doctor or provider must be on the new plan you are applying for;
  - b. You must have had some service from that provider during the 12 months before he or she left your current plan, and;
  - c. You must submit your application to the new insurance carrier within 90 days from the day your provider left your current insurance carrier's network.
  - d. This exception does not apply if provider access is lost because your

insurance carrier is no longer available.

7. Within the rules described below, you have lost or will be losing your group coverage. In order for this exception to apply, you must be applying for coverage because your employer normally employs fewer than 20 employees (as determined under federal rules known as “COBRA”) and is not, therefore, required to offer you “COBRA” coverage. In addition, for the exception to apply,
  - a. You must submit your application to the carrier within the period beginning 90 days before the “qualifying event,” and ending 90 days after the qualifying event (as defined under “COBRA”);
  - b. You had at least 24 months of continuous group coverage immediately prior to the “qualifying event”; and
  - c. The effective date of the individual coverage must be on, or within 90 days after, the date of the “qualifying event.” Under “COBRA,” a “qualifying event” means any of the following events that causes a loss of health coverage: death of the employee; a reduction in hours or a termination of employment (other than by reason of gross misconduct); the divorce or legal separation from the covered employee; the employee becoming entitled to Medicare; a dependent child ceasing to be a dependent child under generally applicable requirements of the health plan; and a bankruptcy filing by an employer from whose employment the employee retired at any time.

## **B. INFORMATION ABOUT THE HEALTH QUESTIONNAIRE**

This health questionnaire was created by the Washington State Health Insurance Pool (WSHIP). It is for people who apply for private, individual medical coverage with insurance carriers.

By completing this form, you will be giving your medical information to the insurance carrier. Your answers will determine if the insurance carrier will accept your application. If the carrier rejects your application, the carrier will refer you to the Washington State Health Insurance Pool (WSHIP). The carrier will send you the notice of rejection, along with information about the types of coverage available through WSHIP, the premiums charged for each plan, and an application for WSHIP coverage. You can also get this information from your insurance agent, from the WSHIP website at [www.wship.org](http://www.wship.org), or by calling WSHIP at 1.800.877.5187. **In order to enroll in WSHIP, you must apply for WSHIP coverage within 90 days of the date your notice of rejection is postmarked.**

When evaluating your application, carriers are not allowed to consider any medical information except for what you provide on this form. The insurance carrier will score your answers using a standard scoring system designed by WSHIP. The insurance carriers do not have control over the questions or the scoring system. If you are rejected for coverage and appeal the rejection, a carrier may then request further medical information. You may choose to supply this added information if you believe it will assist the carrier in scoring your questionnaire correctly. More information about appeals of the scoring may be found in Section D, below.

The scoring documents may be viewed and printed by going to the WSHIP website at <http://www.wship.org>. The documents are also available from the carrier you are applying to or your insurance agent. Contact them directly for a copy. Questions about the scoring of your questionnaire should be directed to the **insurance carrier** you are applying with, or your **insurance agent**, but not to the WSHIP administrator.

The insurance carrier may not reject your application unless the carrier mails its notice of rejection within 15 business days after they have received your completed forms. To be "complete," **this health questionnaire must be signed and dated** with no missing information that might affect your score. The insurance carrier will also have additional forms for you to complete.

Each carrier issues its own "consumer privacy statement" and maintains its own privacy policies - see the specific carrier's privacy statements for details. If you ultimately enroll in a WSHIP plan, WSHIP also maintains strong privacy policies and this information is available on-line at [www.wship.org](http://www.wship.org) or by contacting WSHIP at 1.800.877.5187.

Under RCW 48.43.021, except as otherwise required by statute or rule, a carrier and the Washington State Health Insurance Pool, and persons acting at the direction of or on behalf of a carrier or the pool, 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.

## **C. INSTRUCTIONS FOR COMPLETING THE HEALTH QUESTIONNAIRE**

1. This health questionnaire must be submitted to the insurance carrier, along with your separate application for individual coverage. There are only a few exceptions to this requirement. See "EXCEPTIONS" above.
2. If you answer "yes" to Section A, you may choose to answer each Section B through M, or you may skip to Section III.
3. If you answer "no" to Section A, continue on to Sections B through M; and you must check "yes" or "no" at the top of each Section B through M.
4. Any time you apply for individual coverage or change from one carrier to another, a new health questionnaire will be required.
5. Do not send medical records with this questionnaire. The carriers may not ask for medical records when they process your application.
6. If you are applying for family coverage, a separate questionnaire must be completed for each family member.
7. Make sure that you **sign and date** this health questionnaire and mail it to the insurance carrier along with its completed application forms.

8. If you omit or give false information, you may lose your coverage or delay your enrollment with the Washington State Health Insurance Pool.
9. 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.
10. If you have questions about this form, call the insurance carrier that you are submitting it to, or your insurance agent.

## **D. APPEALS OF HEALTH QUESTIONNAIRE SCORING**

Once a carrier has scored your health questionnaire and notified you that you are either accepted or rejected for coverage, you may request a review if you feel the carrier did not score your health questionnaire correctly or did not respond within the required timeframe. **Contact the insurance carrier directly in writing to request such a review.**

The insurance carrier may not reject your application unless the carrier's notice of rejection is postmarked within 15 business days from the time they had received your completed application and health questionnaire. In other words, if the carrier does not send your rejection within the required time, the carrier may not deny your application in a timely manner. You may apply for coverage with WSHIP during the period that your appeal is under review.

If the carrier does not complete its review within 30 business days of their receipt of your request, or if you have exhausted your appeal rights with the insurance carrier, you may request a review from WSHIP. 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.

WSHIP's review will be limited to whether the carrier correctly applied the scoring tool 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.

A copy of WSHIP's operating rules governing such requests for review may be obtained on the website at [www.wship.org](http://www.wship.org) or by contacting the administrator at 1.800.877.5187.

Send your written request to WSHIP for review, along with:

1. A copy of your completed health questionnaire,
2. The carrier's scoring,
3. Documentation of your appeal request to the carrier,
4. 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

WSHIP will investigate your appeal, consider all information submitted by you, and make its decision within 30 days of receipt of the complete information needed to respond to the appeal. If WSHIP determines that the carrier failed to apply the scoring correctly or provide notice of rejection within the required time period, WSHIP will forward its decision to the carrier.

## PART II MEDICAL CONDITIONS

**DEFINITIONS:** The following is a list of terms used in this questionnaire. These definitions will help you fill out the questionnaire.

**Diagnosed** means a medical condition or disease has been identified by a licensed physician or medical professional operating within the scope of their license.

**Disabling** means that movement, senses, mental or physical abilities are being impaired.

**Hospitalization** means admission of a person for an inpatient stay to a hospital.

**Medicated** means you are taking a prescribed drug under the direction of a licensed physician or other licensed medical professional for the treatment of a medical (including mental) condition.

**Monitored** means you are under the supervision of a licensed physician or other licensed medical professional for an illness or injury.

**Operated** means a surgical procedure performed by a licensed physician or other licensed medical professional.

**Over the counter drugs (OTC)** means medications that can be obtained without a prescription.

**Prescribed drugs** means medications that cannot be dispensed without a prescription.

**Present** means your condition exists or is happening now.

**Recovered** means you no longer have the condition and, therefore, are no longer receiving treatment.

**Treated** means you have received recommended medical care, or your 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.

**Non-treated** means that you have not received recommended medical care for an illness or injury from or at the direction of a licensed physician or other licensed medical professional.

## INSTRUCTIONS

1. Answer the following questions to the best of your knowledge.
2. In each section, answer the question in bold print first.
3. You should look at the list of conditions to help you identify which specific conditions are under each section. Then answer the rest of the questions if you are asked to.
4. The form will tell you what to do after each highlighted question.
5. Do not say that you have, or have had, a condition unless a licensed physician or other qualified licensed medical care provider acting under the scope of their license has told you that you do. If you are unsure if you have, or have had, a condition, ask your medical care provider.
6. If you have a medical condition that is not listed, write it in on the lines provided.
7. If you are currently taking medication, this means that you are currently being "treated." In this case, mark "less than one year ago" (except in Section A, where this does not apply).
8. If you answer "yes" to any condition in Section A, you may choose to answer the entire questionnaire Sections B through M; or you may skip to Part III signature page.

### THE FOLLOWING INFORMATION MUST BE SUPPLIED

Applicant Name _____			
Date of Birth _____			
Contact Phone # _____		Age (if under 18) _____	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height _____	Weight _____

**A. Have you been diagnosed, treated and/or medicated for the following conditions within the last 10 years?**

Yes       No

**If you answer “no” to Section A, continue onto Section B through M; you must check “yes” or “no” at the top of each section.**

**If you answer “yes” to Section A, you may choose to answer each Section B through M, or you may skip to Section III.**

<b>CONDITION</b>		<b>YES</b>
1.	ALS (Lou Gehrig’s disease)	<input type="checkbox"/>
2.	Arteriosclerosis/Artherosclerosis (hardening of the arteries)	<input type="checkbox"/>
3.	Arteritis, Necrotizing	<input type="checkbox"/>
4.	Cirrhosis (Liver)/Portal Hypertension	<input type="checkbox"/>
5.	Coagulation Defect (Hemophilia, Christmas Disease, and other blood factor diseases, exclude Leiden Factor V)	<input type="checkbox"/>
6.	Congestive Heart Failure (includes Cardiomyopathy)	<input type="checkbox"/>
7.	Coronary Artery Disease (including heart attack, angioplasty, bypass)	<input type="checkbox"/>
8.	Cystic Fibrosis	<input type="checkbox"/>
9.	Cytomegalovirus (born with infection, newborn)	<input type="checkbox"/>
10.	Dialysis	<input type="checkbox"/>
11.	Fanconi’s Syndrome	<input type="checkbox"/>
12.	Flexion Contracture of Joints (inability to straighten arms or legs)	<input type="checkbox"/>
13.	HIV+ / AIDS/Kaposi’s Sarcoma	<input type="checkbox"/>
14.	Kidney – Chronic Renal Failure	<input type="checkbox"/>
15.	Kimmelstiel-Wilson Syndrome	<input type="checkbox"/>
16.	Myotonia Congenital (abnormal tone of muscles dating from birth)	<input type="checkbox"/>
17.	Paralysis	<input type="checkbox"/>
18.	Pulmonary Fibrosis	<input type="checkbox"/>
19.	Respirator Dependence (permanent)	<input type="checkbox"/>
20.	Sturge-Weber Syndrome	<input type="checkbox"/>
21.	Superior Vena Cava Syndrome	<input type="checkbox"/>
22.	Tabes Dorsalis / Locomotor Ataxia (caused by Syphilis)	<input type="checkbox"/>
23.	Transplants (completed or recommended; excludes cornea transplant, see #324; excludes kidney donor, see #276)	<input type="checkbox"/>

**B. Have you been diagnosed, treated and/or medicated for cancer in the last 10 years?**     Yes     No

*If yes, fill out the following. If no, go to Section C.*

		Was the cancer local, regional or distant? Local: in the original organ only; Regional: spread to surrounding organs or tissues; Distant: spread directly or by metastasis to other body parts			Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?			
<b>CONDITION</b>		<b>YES</b>	Local	Regional	Distant	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
24.	Brain	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	Cervix/Uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	Colon/Rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	Corpus Uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29.	Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30.	Eye	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31.	Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32.	Hodgkin's and Non-Hodgkin's Lymphoma	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33.	Kidney, Renal Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.	Larynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.	Leukemia – Monocytic / Lymphocytic (all types)	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36.	Leukemia - Myeloid (all types)	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37.	Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38.	Lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39.	Multiple Myeloma	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40.	Nasal Sinus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41.	Oral Cavity, Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42.	Ovary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43.	Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44.	Peritoneum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45.	Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	YES	Was the cancer local, regional or distant? Local: in the original organ only; Regional: spread to surrounding organs or tissues; Distant: spread directly or by metastasis to other body parts			Operated/ Treated/ Medicated		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Local	Regional	Distant	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
<b>Mark only one of the following three #46 (a), (b) or (c).</b>									
46(a). Skin – Basal or Squamous - 1 Previous Excision	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Skin – Basal or Squamous - 2 Previous Excisions	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Skin – Basal or Squamous - 3 Previous Excisions	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Skin - Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Testicular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Thyroid Gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Urinary, Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. All other cancers _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C. Have you been diagnosed, treated and/or medicated for circulatory, blood or heart conditions in the last 10 years?**  Yes  No

*If yes, fill out the following. If no, go to Section D.*

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
53. Agranulocytosis (insufficient white blood cells) Excludes single attacks due to drug sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54(a). Anemias [includes Evans' Syndrome or Hemolytic Icterus (jaundice caused by red cell destruction); excludes iron deficiency and minor Thalassemia with no symptoms; if Pernicious Anemia, do not mark here and go to #54 (b) or (c) and mark there]	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Pernicious Anemia – Normal blood count and hemoglobin	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Pernicious Anemia - Otherwise	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56(a). Angina (no hospitalization within last year and on nitroglycerine)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Angina (no hospitalization within last year, otherwise)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Angina (with hospitalization in the last year)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Aortic Coarctation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Aortic, Mitral or Tricuspid Stenosis (valve) or Pulmonary Stenosis (includes regurgitation/insufficiency other than mild case)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Aortitis	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Arteriovenous Malformation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. Atrial Septal Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Bradycardia (excludes physiological)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Bundle Branch Block	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. Cardiac Arrhythmia (includes PVC, PAT, SVT, Atrial Fibrillation or Flutter, Wolff-Parkinson-White Syndrome)	<input type="checkbox"/>	Previous Episode	Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. Carotid Artery Disease (includes TIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Operated/ Treated/ Medicated		When was condition <b>most recently</b> operated on, treated, or medicated? If not operated on, treated, or medicated, when was condition first diagnosed?			
<b>CONDITION</b>		<b>YES</b>	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
66.	Carotid Sinus Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.	Congenital Heart Disease	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68.	Cor Pulmonale	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69.	Embolism, Pulmonary (present)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70.	Fallot's Tetralogy	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71.	Hepatitis A or E	<input type="checkbox"/>	Recovered <input type="checkbox"/>	Present <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72(a).	Hepatitis B or D, Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).	Hepatitis B or D, Chronic (mild - no Rx)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c).	Hepatitis B or D, Chronic (moderate/severe with Rx)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73(a).	Hepatitis C or G, Acute	<input type="checkbox"/>	Recovered <input type="checkbox"/>	Present <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).	Hepatitis C or G/Autoimmune Hepatitis, Chronic	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
74.	Hepatitis – Chronic Alcohol Related	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.	High Blood Pressure (Hypertension), if controlled by diet leave blank	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76.	High Cholesterol (Hypercholesterolemia) or Hyperlipidemia	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
77.	Mitral Valve Prolapse	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
78.	Osler-Weber-Rendu Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
79(a).	Pacemaker, Successfully Implanted	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).	Pacemaker, Implant Complications	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c).	Pacemaker, Implant Contemplated	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
80.	Patent Ductus Arteriosus or Foramen Ovale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
81.	Periarteritis Nodosa	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
82(a).	Pericarditis - Constrictive, Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).	Pericarditis - Non-constrictive, Not Present, History Due to Infection	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c).	Pericarditis - Non-constrictive, Present	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
83.	Peripheral Vascular Disease (includes leg pain from removed arteries)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Operated/ Treated/ Medicated		When was condition <b>most recently</b> operated on, treated, or medicated? If not operated on, treated, or medicated, when was condition first diagnosed?		
<b>CONDITION</b>	<b>YES</b>	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
84. Phlebitis / Thrombophlebitis / Blood Clots / Deep Vein Thrombosis (exclude single attack)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
85. Polycythemia Vera	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
86. Purpura	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
87(a). Raynaud's Disease-Unoperated: Mild, not progressing, no complications	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Raynaud's Disease-Unoperated: Mild, Otherwise	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Raynaud's Disease-Operated	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d). Raynaud's Disease-Otherwise	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
88. Rheumatic Fever	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
89. Sick Sinus Syndrome	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
90. Splenectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
91. Splenomegaly (Enlargement of Spleen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
92(a). Subacute Bacterial Endocarditis (complete recovery)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Subacute Bacterial Endocarditis - otherwise (with residuals)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
93. Temporal Arteritis	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
94(a). Thromboangiitis (Buerger's Disease), No Current Symptoms and Non-Smoker	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Thromboangiitis (Buerger's Disease), Other	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
95. Varicose Ulcer or Veins (excludes mild cases)	<input type="checkbox"/>	Recovered <input type="checkbox"/>	Present <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
96. Valvulitis (inflammation of heart valves)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
97. Ventricular Septal Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
98. Ventricular Tachycardia (includes PVT)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99. Von Willebrand's Disease	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D. Have you been diagnosed, treated and/or medicated for digestive conditions in the last 10 years?  Yes  No**

*If yes, fill out the following. If no, go to Section E.*

		Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
CONDITION	YES	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
		<input type="checkbox"/>	<input type="checkbox"/>			
100. Anal Fistula	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
101. Bowel, Obstruction or Twisted (Volvulus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
102. Colitis, Ulcerative (Severe Inflammatory Bowel Disease)	<input type="checkbox"/>	Operated <input type="checkbox"/>	Unoperated <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
103. Congenital Familial Polyposis	<input type="checkbox"/>	Operated <input type="checkbox"/>	Unoperated <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
104. Colostomy / Ileostomy (still open)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
105(a). Crohn's Disease (Ileitis) - surgery required or current symptoms	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Crohn's Disease (Ileitis) - no current symptoms	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
106. Diaphragmatic / Hiatal Hernia (includes acid reflux with prescription drug / GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
107. Diverticulitis / Diverticulum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
108. Enterocolitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
109. Fatty Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
110. Fistula of Rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
111(a). Gall Stones present or surgical drainage	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Gall Stones/Gall Bladder surgically removed	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
112. Gastric Conditions not otherwise mentioned in this section (Stomach Conditions, excludes mild stomach aches)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
113. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
114. Hirschsprung's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
115. Intestinal Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
116. Intussusception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
117. Malabsorption Syndrome	<input type="checkbox"/>	Recovered <input type="checkbox"/>	Present <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
118. Mallory Weiss Syndrome (tear of esophagus)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
119. Pancreatic Cyst (excludes simple cyst)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
120(a). Pancreatitis Acute, Single Attack (with unoperated gallstones)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Pancreatitis Acute, Single Attack (with operated gallstones)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Pancreatitis, Chronic	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
121. Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
122. Proctitis (inflammation of the rectum, multiple episodes)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
123. Prolapsed Rectum or Rectocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
124. Pyloric Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
125. Rectal Stricture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
126. Rectal Ulcer (exclude if recovered, no sign of malignancy or Syphilis)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E. Have you been diagnosed, treated and/or medicated for endocrine, lymphatic or metabolic conditions in the last 10 years?  Yes  No**  
**If yes, fill out the following. If no, go to Section F.**

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
127. Acidosis (in last 18 months or uncontrolled)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
128. Acromegaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
129. Addison's Disease	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
130. Celiac / Sprue (unable to digest gluten)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
131(a). Cushing's Syndrome or Disease – present or currently using corticosteroid drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Cushing's Syndrome or Disease – treated or corticosteroid drug use discontinued	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
132. Diabetic Neuropathy, Type I or Type II [Also mark one of #134(a), (b), (c), or (d)]	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
133. Diabetic Retinopathy [Also mark one of #134(a), (b), (c), or (d)]	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
134(a). Diabetes Mellitus, Type I, Uncontrolled	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Diabetes Mellitus, Type I, Controlled (Glycohemoglobin reading of 7 or under)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Diabetes Mellitus, Type II, Uncontrolled	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d). Diabetes Mellitus, Type II, Controlled (Glycohemoglobin reading of 7 or under)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
135. Goiter or Hyperthyroidism or Graves' Disease-Toxic (with excessive production of thyroid hormone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
136. Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
137. Hyperparathyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
138. Hypogammaglobulinemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
139. Hypoparathyroidism (not Hypothyroidism)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
140. Hypopituitarism due to tumor (low production of pituitary hormones)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
141(a). Hypothyroidism (Juvenile onset under 5 years old)-Cretinism, Mild	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Hypothyroidism (Juvenile onset under 5 years old)-Cretinism, Others	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Hypothyroidism (Juvenile onset under 5 years old)-All others	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
142. Niemann-Pick Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
143. Obesity only if with related prior surgery (excludes liposuction)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
144. Pellagra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
145(a). Pituitary Dwarfism – currently in treatment	<input type="checkbox"/>			<input type="checkbox"/>		
(b). Pituitary Dwarfism – no further treatment necessary	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
146. PKU	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
147. Progeria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
148. Sjogren's Syndrome	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
149(a). Thyroid Disease - Single Infection Recovered	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Thyroid Disease - Otherwise (excludes adult hypothyroidism)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**F. Have you been diagnosed, treated and/or medicated for muscle, skeletal or skin conditions in the last 10 years?**

Yes  No

*If yes, fill out the following. If no, go to Section G.*

		Operated/ Treated/ Medicated		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?			
<b>CONDITION</b>		<b>YES</b>	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
150.	Ankylosis (frozen joint, includes adhesive capsulitis) or Spondylosis	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
151.	Arthritis (chronic or severe osteo- or rheumatoid arthritis includes Ankylosing Spondylitis, Degenerative Disk Disease, and Psoriatic Arthritis; excludes conditions that are controlled by aspirin or over-the-counter non-steroidal anti-inflammatory agents such as Motrin)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
152(a).	Back Sprain or Strain or Pain, Single Episode, able to perform usual or modified work (includes Whiplash)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).	Back Sprain or Strain or Pain, Single Episode, Disabling	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c).	Back Sprain or Strain or Pain, Multiple Episodes (2-4)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d).	Back Sprain or Strain or Pain, Chronic (more than 4)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
153.	Bone Disorders (includes Osteoporosis, hip dysplasia; excludes fractures, bunions, or bone spurs)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
154.	Breast Reconstruction pending or performed (for post-mastectomy or fibrocystic disease)	<input type="checkbox"/>	Operated <input type="checkbox"/>	Pending <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
155(a).	Burns, Third Degree (less than 20% of the body)	<input type="checkbox"/>	Under Treatment <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).	Burns, Third Degree (more than 20% of the body)	<input type="checkbox"/>	Under Treatment <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
156.	Cartilage/Ligament/Tendon Conditions (includes Chondritis, Chondromalacia, Torn Cartilage, Torn Meniscus, Torn ACL- regardless of whether repaired; excludes Tendonitis or Tendinitis, see #188)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION		Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
157.	Congenital malformation of limbs (club condition)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
158.	Craniosynostosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
159.	Dermatomyositis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
160.	Diastasis Recti	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
161(a).	Disk, Herniated, Ruptured, or Slipped, no surgery performed, with symptoms	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(b).Disk, Herniated, Ruptured, or Slipped, operated, no current symptoms	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(c).Disk, Herniated, Ruptured, or Slipped, operated, current treatment needed	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
162.	Dislocation [a joint is out of place; recurrent or chronic (not 1 episode)]	<input type="checkbox"/>	Operated <input type="checkbox"/>	Unoperated <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
163.	Dupuytren's Contracture (in hands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
164.	Exostosis (includes bone spurs, outgrowth of bones that cause problems, but not bunions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
165(a).	Fractures (all fractures except skull; excludes minor spine and simple fractures with no surgery)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	(b).Fractures (skull fracture only)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
166.	Gangrene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
167.	Hammertoe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
168.	Hernia (Inguinal, Umbilical, Femoral; others, see diaphragmatic hernia) or Hydrocele (water-filled cyst in scrotum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
169.	Joint Replacement	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
170.	Leprosy (Hansen's Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
171.	Marfan's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
172.	Myofibrositis (inflammation of muscles, includes Fibromyalgia)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
173.	Osteoma (only if surgery recommended)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
174.	Pemphigus	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
175.	Peyronie's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
176. Polymyositis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
177. Prognathism (jaw & bone problems causing buck teeth or other teeth problems, surgery anticipated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
178. Prosthetic Device (on a limb)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
179. Rotator Cuff Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
180. Spina Bifida (present or residual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
181. Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
182(a). Spinal Curvature - Kyphosis (humped back), Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Spinal Curvature - Scoliosis (over 30 degrees of curvature)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
183. Spinal Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
184. Spondylolisthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
185. Stevens-Johnson Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
186. Subcutaneous Emphysema (Recurrent Episodes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
187. Syndactylism (toes or fingers fused together)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
188. Synovitis (which is a joint lining inflammation, includes Tendonitis or Tendinitis; if thumb only, mark #190 only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
189. Temporomandibular Joint Syndrome (TMJ) (surgery anticipated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
190. Tendonitis of Thumb (De Quervain's Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
191. Volkmann's Ischemia (contraction of muscle due to lack of oxygen; exclude if asymptomatic and no treatment required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
192. Von Recklinghausen Disease (includes Neurofibromatosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**G. Have you been diagnosed, treated and/or medicated for non-psychiatric nervous system conditions in the last 10 years?  Yes  No**  
**If yes, fill out the following. If no, go to Section H.**

		Operated/ Treated/ Medicated		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
CONDITION	YES	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
		Recovered	Present			
193. Abscess - Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
194. Bell's Palsy (surgery anticipated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
195. Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
196(a).Cerebral Palsy - Mild (minimal functional impairment)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).Cerebral Palsy - Moderate (able to work or go to school)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c).Cerebral Palsy - Severe (nearly completely disabled or completely disabled)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
197. Chorea's - Includes Huntington's, excludes Sydenham's (neurologic movement disorders other than #208)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
198. Craniotomy (brain operation where skull was opened)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
199. Encephalitis (inflammation of the brain) /Encephalopathy	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
200(a).Epilepsy, Convulsions, or Seizures, partial and primary generalized seizures – currently on no medication to maintain seizure control	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).Epilepsy, Convulsions, or Seizures, partial and primary generalized seizures – on medication to maintain seizure control, or not seizure free for last 2 years	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c).Epilepsy, Convulsions, or Seizures, neonatal, no medication	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d).Epilepsy, Convulsions, or Seizures, neonatal, no medication, normal EEG, no seizures for 1 year	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e).Epilepsy, Convulsions, or Seizures, Febrile seizures, 3 or more	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
201. Guillain-Barre Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
202. Hydrocephalus (water on the brain)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
203. Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Operated/ Treated/ Medicated		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
CONDITION	YES			Less than one year ago	1 to 3 years ago	3 to 10 years ago
		Yes	No			
204. Myasthenia Gravis (neonatal)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
205(a). Myelitis / Transverse Myelitis, Present	<input type="checkbox"/>			<input type="checkbox"/>		
(b). Myelitis / Transverse Myelitis, Complete Recovery	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Myelitis / Transverse Myelitis, With Residual Bowel or Bladder Paralysis, or Neurological Residuals	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d). Myelitis, With Other Paralysis	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
206. Neuritis (include Morton's Neuroma, Neuropathy, lesions of nerves with complaints of pain, hypersensitivity, and possibly altered reflexes)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
207. Polios including treated complications	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
208. Progressive Neuro or Muscular Disorders -Alzheimer's, Demyelinating Disease, Muscular Dystrophy, Multiple Sclerosis, Parkinson's	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
209. Sciatica (include Radiculitis, Radiculopathy)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
210. Stroke, Cerebral, Cerebellar or Brain Stem (including blood clot in brain, excludes TIA)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
211. Subdural Hematoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
212. Thoracic Outlet Syndrome	<input type="checkbox"/>	Recovered	Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
213. Tic Douloureux (includes Trigeminal Neuralgia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
214. Tumor (Brain, Prolactinoma / Pituitary)	<input type="checkbox"/>	Recovered	Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Other	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**H. Have you been diagnosed, treated and/or medicated for psychiatric nervous system conditions in the last 10 years?**     Yes     No

*If yes, fill out the following. If no, go to Section I.*

CONDITION	YES	Operated/ Treated/ Medicated?		If describing a <b>therapy</b> , when was it most recently used? If describing a <b>condition</b> , for how long has it been controlled?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
215. Medications prescribed for psychiatric conditions #216-#221 (indicate conditions below)	<input type="checkbox"/>			<input type="checkbox"/>		
<b>Mark only one of the following #216 (a), (b) or (c).</b>						
216. Phobias, Obsessive-Compulsive Disorders, Post-Traumatic Stress Syndrome, Anxiety Disorders, Panic Attacks, Disassociative Disorders, Mood Disorders						
(a).Mild: Anxiety Adjustment Reaction or situational problems, or acute one episode, non-recurring	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).Moderate: more than one episode, no prior hospitalization, no current counseling	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Severe: prior hospitalization	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d).Active psychotherapy or counseling for the above three conditions	<input type="checkbox"/>			<input type="checkbox"/>		
217. Schizophrenia and/or other psychoses excluding Bipolar Disorders	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
218. Major Depression	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
219. Bipolar Disorders/Manic Depression	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
220. Active psychotherapy or counseling for any of the above three conditions (#217-#219)	<input type="checkbox"/>			<input type="checkbox"/>		
221(a). Non-psychotic Depression or Moderate Depression (Dysthymic disorder, excludes mild depression) - one episode	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Non-psychotic Depression or Moderate Depression (Dysthymic disorder, excludes mild depression) - multiple episodes	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
222. History of electro convulsive therapy (ECT)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
223(a). Alcoholism-current user	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Alcoholism-time period since abstinence	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	YES	Operated/ Treated/ Medicated?		If describing a <b>therapy</b> , when was it most recently used? If describing a <b>condition</b> , for how long has it been controlled?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
224(a). Drug Addiction or Current Dependency (excessive use and abuse of drugs)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Drug Addiction-Past Dependency (excessive use and abuse of drugs)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
225(a). Eating Disorders-Active Treatment (Anorexia Nervosa)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Eating Disorder-Recovered (Anorexia Nervosa)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
226(a). Suicide - single attempt	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Suicide - multiple attempts	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**I. Have you been diagnosed, treated and/or medicated for reproductive system conditions in the last 10 years?**       Yes       No

*If yes, fill out the following. If no, go to Section J.*

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
227. Abnormal Uterine Bleeding (excessive or outside normal period)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
228. Amenorrhea	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
229. Cervical Dysplasia and/or human papillomavirus-HPV (women only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Removed	Present			
230. Cervical Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
231. Cervicitis (cervical erosion or ulcer)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
232. Endometrial Hyperplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
233. Endometriosis (exclude if operated, no symptoms)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
234. Fibroid Tumors, Womb (Uterus)/ Uterine Polyps						
(a). Unoperated, tumor less than 5cm	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Unoperated, tumor greater than 5cm	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
235. Fistula of Vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
236. Hydatid Mole (when pregnant)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
237. Orchitis (inflammation of the testicle) with complications or chronic	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skip the following Ovarian Cyst questions if spontaneously resolved [#238(a)-(c)]</b>						
238(a). Ovarian Cyst-operated	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Ovarian Cyst-controlled by birth control pills	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Ovarian Cyst-otherwise	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
239. Pelvic Inflammatory Disease and Oophoritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
240. Polycystic Ovary Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
241. Priapism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
242(a). Prolapsed Uterus (unoperated, surgery contemplated)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Prolapsed Uterus (unoperated, surgery not contemplated)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
243. Prostate Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
244. Undescended Testicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
245. Uterus, Congenital Defect (surgery anticipated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?			
<b>CONDITION</b>		<b>YES</b>	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
246.	Varicocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I.	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**J. Have you been diagnosed, treated and/or medicated for respiratory system conditions in the last 10 years?**       Yes       No

*If yes, fill out the following. If no, go to Section K.*

CONDITION	YES	Operated/ Treated/ Medicated		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
247. Abscess - Lung	<input type="checkbox"/>	Recovered <input type="checkbox"/>	Present <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
248. Asbestosis	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
249(a). Asthma (mild/seasonal)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Asthma (moderate)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Asthma (severe)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
250. Bronchiectasis (not Bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
251. Bronchitis, Chronic (continuous or periodic for over a 2-year period)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
252. Extrinsic Allergic Alveolitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
253. Fistula of Throat/Lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
254. Histoplasmosis (with Pulmonary Involvement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
255. Hyaline Membrane Disease (Newborn Respiratory Distress Syndrome)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
256(a). Pleurisy (if not fully recovered; no effusion)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Pleurisy (if not fully recovered; pleural effusion unresolved)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Pleurisy (if not fully recovered; pleural effusion resolved)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
257. Pneumoconiosis (lung disease caused by minerals and fibers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
258. Pneumonia (single or multiple episodes, hospitalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
259. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
260(a). Pulmonary Emphysema, Mild (not requiring medicine; includes COPD)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Pulmonary Emphysema, Moderate (requiring medicine; includes COPD)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Pulmonary Emphysema, Severe (with Dyspnea, includes required home oxygen or Alpha I, antitrypsin emphysema if injectable replacement therapy required; includes COPD)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Operated/ Treated/ Medicated		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
<b>CONDITION</b>	<b>YES</b>	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
261. Pulmonary Hypertension (Lung condition, not high blood pressure)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
262. Pulmonary Osteoarthropathy (arthritis caused by lung cancer)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
263. Sleep Apnea only if surgery contemplated or completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
264. Tuberculosis Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
265. Valley Fever (Coccidioidomycosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
266. Wegener's Granulomatosis	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Other						
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**K. Have you been diagnosed, treated and/or medicated for urinary system conditions in the last 10 years?**       Yes       No

*If yes, fill out the following. If no, go to Section L.*

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
267. Bladder Conditions (lack of voluntary control, includes Neurogenic; excludes Stress Incontinence)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
268. Bladder Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
269. Blood in the Urine (Hemoglobinuria, all causes except Cystitis and benign conditions)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
270(a). Cystitis, Interstitial (a chronically unstable and painful inflammatory bladder condition diagnosed by a physician)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Cystitis, Chronic (a chronically unstable and painful inflammatory bladder condition of long duration or disease with little change or slow progression)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
271. Cystocele (prolapsed bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
272. Hydronephrosis (blockage in urinary tract causing backup of urine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
273. Hypospadias (abnormal outlet of urethra on penis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
274(a). Kidney Cyst-Simple and Benign (surgery contemplated)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Kidney Cyst-Simple and Benign (after surgery or none contemplated)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Kidney Cyst-Other Cysts including Polycystic	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
275. Kidney - Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
276(a). Nephrectomy (removal of kidney)- With kidney abnormalities or due to tuberculosis or cancer	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Nephrectomy (removal of kidney)- With no residual complications	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated, or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
277(a). Nephritis (inflammatory reaction of kidney)-Single Acute Attack	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Nephritis (inflammatory reaction of kidney)-Chronic	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
278. Perinephric Abscess (abscess in tissue surrounding the kidney)	<input type="checkbox"/>	Recovered <input type="checkbox"/>	Present <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
279(a). Pyelonephritis (infection of kidney and collecting system of the urinary tract)-Acute: single episode, completely recovered	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Pyelonephritis (infection of kidney and collecting system of the urinary tract)-Acute: 2 - 4 attacks/episodes	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Pyelonephritis (infection of kidney and collecting system of the urinary tract)-Acute: more than 4 attacks/episodes	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d). Pyelonephritis (infection of kidney and collecting system of the urinary tract)-Chronic and/or Vesicoureteral Reflux	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
280(a). Renal Abscess-Present	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Renal Abscess-Treated	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
281(a). Renal Failure-Complete recovery, normal kidney function	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Renal Failure-Otherwise	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
282. Renal Insufficiency	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
283. Uremia	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
284. Ureteral or Urethral Stricture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Other	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**L. Have you been diagnosed, treated and/or medicated for any of the other conditions listed below in the last 10 years?**  Yes  No  
*If yes, fill out the following. If no, go to Section M.*

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
285. Cellulitis	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
286. Chronic Cystic Mastitis (includes Fibrocystic disease of the breast)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
287. Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
288. Collagen Vascular Diseases (other than Lupus, Rheumatoid Arthritis, Scleroderma or Dermatomyositis; includes Polyarteritis Nodosa, and Thrombocytopenia)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
289. Congenital Abnormalities (For the following body systems or conditions: Central Nervous, Chromosomes, Dental, Ear with hearing impairment, Eye, Face, Genital & Urinary System, Limbs, Mouth, Muscular-skeletal, Respiratory, Spinal Cord, Stomach and Throat, and Vertebrae. Check only if significant medical intervention is required, including surgery)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
290. Cysts with Involvement of Critical Organs	<input type="checkbox"/>	Operated <input type="checkbox"/>	Present <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
291. Edema (brain, retinal, pharynx, corneal, optic nerve, larynx)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
292. Fainting (severe or frequent attacks; 5 or more attacks)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
293(a). Lupus-Discoid (no complications)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Lupus-Discoid (otherwise)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
294. Lupus-Systemic Lupus Erythematosus	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
295. Peritonitis (Abdominal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	YES	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
		Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
296(a). Polyps-Bladder (benign)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Polyps-Gastrointestinal or Rectum (benign) – fewer than 4 polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Polyps-Gastrointestinal or Rectum (benign) – 4 or more polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
297. Sarcoidosis, (Boeck's)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
298. Scleroderma	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
299(a). Sexually Transmitted Diseases (excludes HPV and Syphilis)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Sexually Transmitted Diseases (includes Syphilis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
300(a). Toxoplasmosis (Present Under Age 5 or Pregnant Woman)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Toxoplasmosis (Present Over Age 5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Toxoplasmosis (Complete Recovery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
301. Turner's Syndrome	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EAR, NOSE, THROAT</b>						
302. Acoustic Neuroma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
303. Cholesteatoma of the Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
304. Cleft Lip, Nose, Palate or Harelip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
305. Cystic Hygroma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
306. Deviated Septum (only if surgery anticipated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
307. Esophageal Achalasia, Stricture, Ulcer or Varicosities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
308. Meniere's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
309. Otosclerosis (Surgery Anticipated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
310. Polyps (nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
<b>CONDITION</b>	<b>YES</b>	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
<b>EAR, NOSE, THROAT</b>						
311. Sinusitis Chronic (infection diagnosed by a physician, lasting over 6 weeks and not responding to initial antibiotics)						
(a). On medication, no future surgery anticipated	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). On medication, surgery anticipated	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c). Operated, no medications	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
312. Speech, loss of (Aphonia)	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYE</b>						
313. Blepharoptosis (permanent eye lid problem)						
(a). One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
314. Cataracts						
(a). One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
315. Corneal Degeneration or Ulcers						
(a). One eye	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Two eyes	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
316. Detached Retina						
(a). One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
317. Ectropian						
(a). One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
318. Glaucoma						
(a). One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
319. Keratoconus						
(a). One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
320. Macular Degeneration						
(a). One eye	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b). Two eyes	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on, treated or medicated, when was condition first diagnosed?		
<b>CONDITION</b>	<b>YES</b>	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
<b>EYE</b>						
321. Optic Atrophy / Neuritis						
(a).One eye	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).Two eyes	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
322. Strabismus (cross-eyed)						
(a).One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
323. Trachoma (chronic inflammation of the outer eye)						
(a).One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
324. Transplants, Cornea						
(a).One eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b).Two eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Other						
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**M. Have you been diagnosed, treated and/or medicated for any other conditions not listed in the previous pages in the last 10 years?**

Yes

No

*If yes, fill out the following.*

	Operated/ Treated/ Medicated?		When was condition <b>most recently</b> operated on, treated or medicated? If not operated on or treated, or medicated, when was condition first diagnosed?		
<b>CONDITION</b>	Yes	No	Less than one year ago	1 to 3 years ago	3 to 10 years ago
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**NOTE:** You must complete this section by checking “yes” or “no.”

### PART III

**Signature – adult applicants must sign this form. 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 Section A, I have completed all remaining sections, B through M of Part II, and checked “yes” or “no” at the top of each section.
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 face legal action and monetary penalties.**

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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

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

**For Insurance Carrier Use Only. Do Not Mark This Section.**

Name of Carrier _____	
Date Reviewed _____	Reviewer ID _____
Condition #(s) _____	Score _____
Condition #(s) _____	Score _____
Condition #(s) _____	Score _____
Condition #(s) _____	Score _____
Condition #(s) _____	Score _____
Condition #(s) _____	Score _____
Condition #(s) _____	Score _____
Total Score _____	
Applicant Accepted _____	Applicant Declined _____