



Athens Area Health Plan Select, Inc.
Medical Questionnaire
(2-25 enrolling)

Employee Name: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employee: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Spouse: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Dependent: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Dependent: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Dependent: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Dependent: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Dependant: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Health Questions:

All of the following questions must be answered with respect to each person for whom you are applying for coverage. Indicate if anyone listed on this application within the past 10 years had medical advice, treatment, or if you have reasons to know of health problems in regard to the following, then check Yes or No to each question. Questions answered Yes must be explained in detail in the space(s) provided on page three.

1. Circulatory System

- Y N Heart attack
Y N Stroke
Y N Pacemaker
Y N Angioplasty or coronary artery by-pass (CABG)
Y N High blood pressure
Y N Coronary artery disease (angina pectoris, coronary insufficiency, thrombosis, occlusion)
Y N Elevated Cholesterol and or Triglyceride levels
Y N Anemia or blood disorder
Y N Peripheral Vascular Disease (PVD)
Y N Congestive Heart failure
Y N Congenital Heart disease (abnormality at birth)

2. Digestive System

- Y N Ulcers
Y N Acid Reflux for which you take prescription medication
Y N Heartburn for which you take prescription medication
Y N Liver/Pancreas disorder, Hepatitis
Y N Intestinal disorder (Colitis, Crohn's disease)
Y N Hernia
Y N Rectal disorder

3. Genitourinary System

- Y N Menstrual disorder for which you take an injection medicine
Y N Genital disorder
Y N Sexual dysfunction
Y N Pregnancy complications (premature birth, miscarriage, c-section)
Y N Infertility
Y N Bladder disorder
Y N Prostate disorder
Y N Do you have any degree of Kidney impairment

4. Endocrine System

- Y N Diabetes- Insulin dependant, Non-Insulin dependant
Y N Thyroid disease -benign, Hyperthyroidism, Hypothyroidism.
Y N Thyroid cancer.
Y N Enlargement of the lymph-nodes
Y N Connective tissue disorder
Y N Abnormal production of growth hormones



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**5. Respiratory System**

- Y N Allergies-seasonal, Immunotherapy required, Anaphylaxis reaction requiring epinephrine
- Y N Asthma
- Y N Emphysema
- Y N Sinus or nasal disorder
- Y N Lung disease or disorder

**7. Nervous System**

- Y N Epilepsy or other seizures
- Y N Migraines, headaches of any type
- Y N Multiple Sclerosis
- Y N Parkinson disease
- Y N Cerebral Palsy-mild, moderate or severe.

**9. Behavioral Health**

- Y N Attention deficit disorder
- Y N Neurotic disorder (anxiety, panic disorders, obsessive-compulsive.
- Y N Psychotic disorder (schizophrenia, paranoia, manic and severe depression)
- Y N Suicide attempt
- Y N Eating disorder
- Y N Depression

**11. Other**

- Y N Organ or other type of transplant or implant
- Y N Breast disorder
- Y N Alcohol or drug abuse
- Y N Lupus

**6. Muscular or Skeletal**

- Y N Rheumatoid or Psoriatic arthritis
- Y N Osteoarthritis
- Y N Fibromyalgia
- Y N Back disorder or chronic back pain
- Y N Spinal Cord injury
- Y N Joint disorder
- Y N Chronic fatigue syndrome
- Y N Carpal Tunnel Syndrome

**8. Cancer**

- Y N Cancer –local, regional or distant. gland/organ effected \_\_\_\_\_
- Y N Tumor-Malignant or Benign
- Y N Carcinoma in Situ (localized malignant lesion)
- Y N other \_\_\_\_\_
- Y N Karposi's Sarcoma

**10. Ear or Eye**

- Y N eye disorder
- Y N ear disorder

- 12. Has any person on this application, within the last 5 years, been hospital-confined or had surgery? Y N
- 13. Has any person on this application ever been advised to undergo a surgical operation which was not performed? Y N
- 14. Has any person on this application been advised to undergo surgery within the next six months? Y N
- 15. Is any person on this application currently pregnant? List prior complications, including cesarean section. (If yes, indicate anticipated date of delivery) Y N
- 16. Is any person on this application currently taking any medication, undergoing treatment or therapy? List all medications taken within the past 12 months. Y N
- 17. Has any person on this application smoked within the last 5 years? Y N
- 18. Has any person on this application been told he or she had an infection/immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), sexually transmitted diseases or Lyme disease? Y N

