



Application for Individual Comprehensive Health Insurance

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

Applicant Information

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

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

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

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

Producer Information:

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

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

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

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

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

Notification: Broker Only
 Broker and Subscriber

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

YOU MUST COMPLETE THIS SECTION – even if you are not currently applying for HIPAA coverage.
Mercy Health Plans has underwriting criteria that you may not meet because of your health conditions. If you do not qualify for one of our standard plans because of your health, you may still qualify for one of the plans that are available as a result of HIPAA (Health Insurance Portability and Accountability Act of 1996).

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

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

Are you applying for a HIPAA plan? Yes No

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

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

- 1) Type of coverage: Applicant only (Ages 19-65 yrs.) Child Only (Age 6 mos. – 18 yrs.) Applicant & spouse
 Applicant & unmarried children* Applicant, spouse & unmarried children*
 * Unmarried dependent children up to age 25.
- 2) Effective date requested: ____/____/_____
Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.
- 3) OPTIONAL RIDERS: Family Services Rider – Additional \$ 4.50 /month Yes No
- 4) Select Plan Option: Choose ONLY ONE Plan option.
Note: Maternity benefits apply only to the applicant or applicant's spouse, and will not begin for one year.

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

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

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
<input type="checkbox"/> E	12 month	No	\$1,000	\$2,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> G	12 month	No	\$5,000	\$10,000	\$15/\$35	80/60%	\$10/\$40/\$65

Health History:

Complete your health history by answering “Yes” or “No” to the questions in the following section.

If you are only applying for the HIPAA plan, you do not need to fill out the Health History section of this application.

- 1) Have you or any family member(s) who are applying for coverage smoked or used other smokeless tobacco products within the last 12 months? Yes No
- 2) Are you or any family member(s) who are applying for coverage currently pregnant? Yes No
- 3) Do you or any family member(s) who are applying for coverage have any health conditions that a reasonably prudent person would anticipate requiring future medical treatment or surgery within the next 12 months? Yes No
If so, what are those health conditions, and what treatments are considered? (Attach other pages if needed)

- 4) In the last ten years have you or any family member(s) applying for coverage had any signs, symptoms, indications, diagnoses or treatment of any disease, disorder or injury, or had any test results that were abnormal? Yes No
If so, what are those disease states, injuries or abnormal test results? (Attach other pages if needed)

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

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

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

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

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

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

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

7) **SELF**

Primary physician name and phone number: _____

Date of last physical exam: ____ / ____ / ____

SPOUSE

Primary physician name and phone number: _____

Date of last physical exam: ____ / ____ / ____

Statements of Understanding:

Please read all statements below. Each person, age 18 or over, to be covered on this policy will need to sign at the bottom of page 6.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans.
2. I understand that I will receive either an acceptance or denial from MHP or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application
3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full.
4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.
5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical condition disclosed within this application will not be covered for up to 12 months after my effective date.
6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage will be rescinded in its entirety at MHP's discretion. **EXCEPTION: This does not apply to the HIPAA plans.**
7. I understand that I, or any of my covered family members, may need to obtain a physical examination at my own expense prior to acceptance for coverage, if such an examination has not been performed within the last two years.
8. I understand that I, or any of my covered family members, must notify Mercy Health Plans if we seek and receive medical attention from the time this application is completed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change. **EXCEPTION: This does not apply to the HIPAA plans.**
9. I understand that if I purchase maternity benefits, they apply only to my spouse or me and do not begin until we have been covered for 12 months under the plan that includes the maternity benefit. Maternity benefits are not available for our dependent children and do not apply to child only plans.
10. I understand and agree that Mercy Health Plans may obtain information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.
11. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.

Authorization to Use and Disclose Protected Health Information

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

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

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

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

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

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

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

	Signature:	Printed Name:	Relationship to Applicant:	Date:
Applicant (or Parent/Legal Guardian if under age 18)				
Applicant's Spouse				
Dependent Child 1				
Dependent Child 2				
Dependent Child 3				
Dependent Child 4				
Dependent Child 5				
Dependent Child 6				

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

Payment Information:

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

Please check your method of payment:

Automatic Bank Account Withdrawal

- Checking account (attach voided check below)
- Savings Account

Account # _____

Routing # _____

Credit Card

- VISA MasterCard

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

Billing Address _____

City _____ **State** _____ **Zip** _____

Telephone _____

Credit Card Number: _____

Expiration Date (month/year): ____/____

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

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

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

Signature of Cardholder

Date

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

.....

Attach Voided Check Here

AMENDMENT II
to the
Application for Individual Comprehensive Health Insurance
PHI MO INDIV APP/LT (01/08)

This document hereby amends the Application for the Individual Comprehensive Health Insurance policy. Except for these Amendments, the terms of your Policy continues in full force and effect.

I Page 1 – Producer Information Section is revised as follows:

DELETE: “(Does not include HIPAA applicants.)”

II. Page 2 – This section is DELETED IN ITS ENTIRETY:

YOU MUST COMPLETE THIS SECTION – even if you are not currently applying for HIPAA coverage.
Mercy Health Plans has underwriting criteria that you may not meet because of your health conditions. If you do not qualify for one of our standard plans because of your health, you may still qualify for one of the plans that are available as a result of HIPAA (Health Insurance Portability and Accountability Act of 1996).

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

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

Are you applying for a HIPAA plan? Yes No

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

III. Pages 2 and 3 – The HIPAA Plans below are DELETED IN THEIR ENTIRETY. These plans will no longer be offered.

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

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
<input type="checkbox"/> SPG-F-35	12 month	No	\$2,500	\$5,000	\$35/\$45	80/60%	\$15/\$40/\$60
<input type="checkbox"/> SPG-G-35	12 month	No	\$5,000	\$10,000	\$35/\$45	80/60%	\$15/\$40/\$60

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
<input type="checkbox"/> [StL]-E	12 month	No	\$1,000	\$2,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> [StL]-G	12 month	No	\$5,000	\$10,000	\$15/\$35	80/60%	\$10/\$40/\$65

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
<input type="checkbox"/> Mid-MO -E	12 month	No	\$1,000	\$2,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> Mid-MO -G	12 month	No	\$5,000	\$10,000	\$15/\$35	80/60%	\$10/\$40/\$65

IV. Page 3 – The instruction box for the Health History section is DELETED AND REPLACED by the following:

Health History:

Complete your health history by answering “Yes” or “No” to the questions in the following section.

V. Page 5 – The Statement of Understanding is revised as follows:

Item #6: **DELETE**, “Exception: This does not apply to HIPAA plans.”

Item #8: **DELETE**, “Exception: This does not apply to HIPAA plans.”



Charles S. Gilham, Vice President
Mercy Health Plans

SECONDARY QUESTIONS TO THE APPLICATION FOR INDIVIDUAL HEALTH INSURANCE

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



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

	YES	NO		YES	NO												
1. Diabetes/Abnormal Blood Sugar																	
Which family member(s) has diabetes/pre-diabetes/hypoglycemia?																	
Diabetes/Pre-diabetes? <input type="checkbox"/> YES <input type="checkbox"/> NO Which type of diabetes has been diagnosed? Type I, Insulin Dependent <input type="checkbox"/> YES <input type="checkbox"/> NO If Type I, # units of insulin per day? <input type="checkbox"/> < 75 units <input type="checkbox"/> > 100 units <input type="checkbox"/> 75-100 units <input type="checkbox"/> Don't know Type II, Non-Insulin dependent <input type="checkbox"/> YES <input type="checkbox"/> NO Gestational <input type="checkbox"/> YES <input type="checkbox"/> NO Other type/Don't know <input type="checkbox"/> YES <input type="checkbox"/> NO Date initial diagnosis made (in MMYYYY)? _____/_____/_____ Oral meds to control blood sugar? <input type="checkbox"/> YES <input type="checkbox"/> NO			Average glucose levels within last six months. If fasting glucose levels <input type="checkbox"/> 65-115 <input type="checkbox"/> 116-175 <input type="checkbox"/> >175 If random glucose levels <input type="checkbox"/> <200 <input type="checkbox"/> 201-250 <input type="checkbox"/> >250 In addition, does patient have any of these conditions? Diabetic eye complications <input type="checkbox"/> YES <input type="checkbox"/> NO Peripheral neuropathy <input type="checkbox"/> YES <input type="checkbox"/> NO High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO Coronary Artery Disease <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney Problems/Renal Failure <input type="checkbox"/> YES <input type="checkbox"/> NO Hypoglycemia <input type="checkbox"/> YES <input type="checkbox"/> NO														
2. Endocrine System/Thyroid																	
Which family member(s) has endocrine system/thyroid condition?																	
Hyperthyroidism/Hashimoto's Thyroiditis/Graves Disease - excess thyroid hormone <input type="checkbox"/> YES <input type="checkbox"/> NO What kind of treatments have you had for this? <input type="checkbox"/> Surgery <input type="checkbox"/> Radioactive Iodine <input type="checkbox"/> Other _____ If surgery, date it was done (in MMYYYY)? _____/_____/_____ Does medical/RX management control disease? <input type="checkbox"/> YES <input type="checkbox"/> NO Hypothyroidism-low thyroid hormone <input type="checkbox"/> YES <input type="checkbox"/> NO Toxic Thyroid Goiter-Plummer's Disease <input type="checkbox"/> YES <input type="checkbox"/> NO When was diagnosis made (in MMYYYY)? _____/_____/_____ Hyperparathyroidism <input type="checkbox"/> YES <input type="checkbox"/> NO Did you have surgery for? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, does medication control disease? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, give date of surgery (in MMYYYY)? _____/_____/_____			Hyperaldosteronism (Cushing's Disease) <input type="checkbox"/> YES <input type="checkbox"/> NO Is the cause of disease known? <input type="checkbox"/> YES <input type="checkbox"/> NO If cause is known, describe condition, below _____ _____ _____ Date condition diagnosed (in MMYYYY)? _____/_____/_____ Is the condition stable with treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO Addison's Disease (Chronic Adrenal Insufficiency) <input type="checkbox"/> YES <input type="checkbox"/> NO Growth Hormone Deficiency <input type="checkbox"/> YES <input type="checkbox"/> NO Other Thyroid/Endocrine system disorder <input type="checkbox"/> YES <input type="checkbox"/> NO Please describe condition below _____ _____														
3. High Blood Pressure/Hypertension																	
Which family member(s) has high blood pressure?																	
_____ THREE recent blood pressure readings in systolic/diastolic format <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 33%;">Systolic</th> <th style="width: 33%;">Diastolic</th> <th style="width: 33%;">Date Taken</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			Systolic	Diastolic	Date Taken										Readings taken while on meds for hypertension? <input type="checkbox"/> YES <input type="checkbox"/> NO Diagnosed with malignant hypertension? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Systolic	Diastolic	Date Taken															

	YES	NO		YES	NO
4. Heart/Circ/Stroke/Aneurysm/Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			
Which family member(s) has a heart/circulatory system condition?			Arrhythmias/Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
			Episodes are: <input type="checkbox"/> Single <input type="checkbox"/> Multiple <input type="checkbox"/> Chronic		
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	If multiple, are they controlled?	<input type="checkbox"/>	<input type="checkbox"/>
Which type of aneurysm?			If YES, are they controlled: <input type="checkbox"/> Drugs <input type="checkbox"/> Surgical device		
<input type="checkbox"/> Abdominal/Descending Thoracic Aortic			Cause known for arrhythmias?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brain <input type="checkbox"/> Femoral/Peripheral <input type="checkbox"/> Other type			If cause known, describe: _____		
Has aneurysm been operated on?	<input type="checkbox"/>	<input type="checkbox"/>	Conduction disturbances/Bundle Branch Blocks	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was surgery (in MMYYYY)	<input type="checkbox"/>	<input type="checkbox"/>	Cause known for conduction disturbances?	<input type="checkbox"/>	<input type="checkbox"/>
If no, any further problems?	<input type="checkbox"/>	<input type="checkbox"/>	If cause known, describe: _____		
Is aneurysm inoperable?	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac implantable device/pacemaker installed?	<input type="checkbox"/>	<input type="checkbox"/>
Is aneurysm small and asymptomatic?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of surgery? _____/_____/_____		
Hypercholesterolemia/Hyperlipidemia/High blood lipids/			What is the diagnosis:		
High blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bundle Branch Block <input type="checkbox"/> Sick Sinus Syndrome		
Secondary to another condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> AV Block <input type="checkbox"/> Other		
If yes, describe condition: _____			<input type="checkbox"/> Complete 3rd Degree Block <input type="checkbox"/> Don't Know		
What are cholesterol levels (in mg/dl)?			Chest pain/Angina/Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <=220 <input type="checkbox"/> >220<=250 <input type="checkbox"/> >250<=300 <input type="checkbox"/> >300			Is clinical work up suggestive of coronary artery		
Are above levels while on cholesterol meds?	<input type="checkbox"/>	<input type="checkbox"/>	disease/blocked cardiac arteries?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	If no, date of onset of symptoms? _____/_____/_____		
What type of anemia do you have:			Is cause known for chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unknown/Other <input type="checkbox"/> Thalassemia Major			If cause is known, describe: _____		
<input type="checkbox"/> Pernicious <input type="checkbox"/> Iron Deficiency			Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Hemolytic Anemia			Do you currently have one of these conditions?	<input type="checkbox"/>	<input type="checkbox"/>
If hemolytic, is cause of hemolysis known?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had: <input type="checkbox"/> Single episode <input type="checkbox"/> Multiple episodes		
If hemolytic, have you had a splenectomy?	<input type="checkbox"/>	<input type="checkbox"/>	If single episode, date of onset of symptoms? _____/_____/_____		
If yes, when was surgery (in MMYYYY)	_____/_____/_____		If multiple, date recovered from last episode? _____/_____/_____		
Bleeding disorders/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Are you on anti-clotting RX?	<input type="checkbox"/>	<input type="checkbox"/>
What type of bleeding disorder has been diagnosed:			Edema/Swelling of the extremities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Christmas disease (Factor IX)			Do you know what is causing swelling?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hemophilia A (Factor VIII)			If yes, describe: _____		
<input type="checkbox"/> Oslo-Weber-Rendo disease			Cardiac Valve disorders/Heart Murmur/Mitral Valve Prolapse/		
<input type="checkbox"/> Other type of hemophilia			Mitral Regurgitation/Mitral Stenosis	<input type="checkbox"/>	<input type="checkbox"/>
If other, more than one bleeding episode a year?	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease/Heart Attack/			If yes, was the valve: <input type="checkbox"/> Repaired <input type="checkbox"/> Replaced		
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of surgery: _____/_____/_____		
Have you had? <input type="checkbox"/> Angioplasty <input type="checkbox"/> Cardiac Bypass Surg			If no, is the patient symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neither Angioplasty nor Bypass Surgery			Heart Transplant	<input type="checkbox"/>	<input type="checkbox"/>
If performed, date procedure done? _____/_____/_____			Have you had a heart transplant?	<input type="checkbox"/>	<input type="checkbox"/>
If bypass surg, any cardiac problems since?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of surgery: _____/_____/_____		
If subsequent problems, date resolved? _____/_____/_____			Are you on the waiting list for a transplant?	<input type="checkbox"/>	<input type="checkbox"/>
If no angioplasty/bypass, prior heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
If history of heart attack, give date: _____/_____/_____			Are you on the waiting list for heart transplant?	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Do you know what is causing cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>
Is the only treatment drug therapy?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, describe: _____		
Have you had any hospitalizations for?	<input type="checkbox"/>	<input type="checkbox"/>			
Carotid Artery Occlusion	<input type="checkbox"/>	<input type="checkbox"/>			
Is disease symptomatic and documented?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had surgery to correct?	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiomegaly/Enlarged hear	<input type="checkbox"/>	<input type="checkbox"/>			
Are you a heart transplant candidate?	<input type="checkbox"/>	<input type="checkbox"/>			
Is the reason for the enlargement known?	<input type="checkbox"/>	<input type="checkbox"/>			
If known, describe: _____					
Do you have any impairment from condition?	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
4. Heart/Circ/Stroke/Aneurysm/Cholesterol (Continued)					
Peripheral Vascular Disease/Claudication	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Vascular Accident (CVA)/Stroke/ Transient Ischemic Attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>
Is diagnosis?	<input type="checkbox"/> Reynaud's Disease	<input type="checkbox"/> Buerger's Disease	Was diagnosis CVA or TIA?	<input type="checkbox"/> CVA	<input type="checkbox"/> TIA
	<input type="checkbox"/> Neither Reynaud's or Buerger's		Give date symptoms present themselves:	____/____/____	
If Reynaud's, has sympathectomy been done?	<input type="checkbox"/>	<input type="checkbox"/>	Any residual impairment?	<input type="checkbox"/>	<input type="checkbox"/>
If Reynaud's, is condition rapidly progressing?	<input type="checkbox"/>	<input type="checkbox"/>	Pericarditis	<input type="checkbox"/>	<input type="checkbox"/>
If Buerger's, date symptoms presented?	____/____/____		Is diagnosis restrictive pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
If Buerger's, any incidences of gangrene?	<input type="checkbox"/>	<input type="checkbox"/>	If no, was there only a single episode?	<input type="checkbox"/>	<input type="checkbox"/>
If neither, date diagnosis made?	____/____/____		If no, was there any residual cardiac damage?	<input type="checkbox"/>	<input type="checkbox"/>
If neither, any amputations?	<input type="checkbox"/>	<input type="checkbox"/>	If no, give date symptoms presented?	____/____/____	
If neither, more than one hospitalization for?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, did the patient have surgery?	<input type="checkbox"/>	<input type="checkbox"/>
			If surgery, give date of surgery:	____/____/____	
			Other disease of the heart or circulatory system	<input type="checkbox"/>	<input type="checkbox"/>
			Please describe condition: _____		

	YES	NO		YES	NO
5. Respiratory/Lung Disorder/Asthma/TB					
Which family member(s) has a respiratory system condition?	<input type="checkbox"/>	<input type="checkbox"/>	How would you characterize symptoms?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism/Pulmonary Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have:	<input type="checkbox"/> Asthma & Allergies		Is it known what caused embolism/infarction?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Allergies Only	<input type="checkbox"/> Asthma Only	Please describe condition: _____		
If allergies, are you on desensitization shots?	<input type="checkbox"/>	<input type="checkbox"/>	Single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
If asthma, are attacks occasional or frequent?	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent		Does patient have phlebitis-blood clots in legs?	<input type="checkbox"/>	<input type="checkbox"/>
If asthma, any hospitalizations for?	<input type="checkbox"/>	<input type="checkbox"/>	When did symptoms last occur (in MMYYYY)?	____/____/____	
If asthma, nebulizer used for acute episodes?	<input type="checkbox"/>	<input type="checkbox"/>	Is patient continuing anticoagulant drug treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If asthma, are you taking corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient fully recovered?	<input type="checkbox"/>	<input type="checkbox"/>
Is asthma under control with medications?	<input type="checkbox"/>	<input type="checkbox"/>	Dyspnea/Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Is the shortness of breath exercise induced?	<input type="checkbox"/>	<input type="checkbox"/>	Any underlying condition causing this?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Please describe underlying condition: _____		
In last two years number of hospitalizations for bronchitis?	<input type="checkbox"/> not at all <input type="checkbox"/> one time <input type="checkbox"/> > than once		Is the shortness of breath exercise induced?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Lung Disease (COPD)/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how would you characterize symptoms?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Have there been any hospitalizations for?	<input type="checkbox"/>	<input type="checkbox"/>	Other respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was there more than one hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	Please describe other condition: _____		
Sinusitis/Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>	Are you a recipient or candidate for a transplant?	<input type="checkbox"/>	<input type="checkbox"/>
Is the condition chronic?	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			
Check one:	<input type="checkbox"/> Currently have <input type="checkbox"/> Recovered from				

		YES	NO			YES	NO
6. Ear/Eye/Nose/Throat/Skin		<input type="checkbox"/>	<input type="checkbox"/>				
Which family member(s) has an EENT or skin condition?				Psoriasis			
_____				Episodes are: <input type="checkbox"/> Mild <input type="checkbox"/> Severe			
Middle ear infections/tubes in ears/Otitis Media	<input type="checkbox"/>	<input type="checkbox"/>		Cellulitis-skin infection			
Are infections chronic?	<input type="checkbox"/>	<input type="checkbox"/>		More than one episode?			
Has there been more than one infection?	<input type="checkbox"/>	<input type="checkbox"/>		Are the episodes severe?			
Are tubes present in ear canals?	<input type="checkbox"/>	<input type="checkbox"/>		When was since last episode (in MMYYYY)?			
Date of most recent episode (in MMYYYY)?	____/____/____			_____			
Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>		Tonsillitis			
Has there been surgery for the condition?	<input type="checkbox"/>	<input type="checkbox"/>		Has the patient had surgery for?			
If yes, when was surgery (in MMYYYY)?	____/____/____			Single episode of symptoms?			
If yes, is further surgery needed?	<input type="checkbox"/>	<input type="checkbox"/>		Date of last episode of symptoms (in MMYYYY)?			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>		_____			
Both eyes?	<input type="checkbox"/>	<input type="checkbox"/>		Sinusitis/Sinus Infection			
Have you had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>		Is condition chronic?			
If YES, date it was done (in MMYYYY)?	____/____/____			How many infections do you have a year?			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Other Ear/Eye/Nose/Throat or Skin condition			
If yes, provide current ocular pressure	_____			Any hearing impairment or implant?			
				Please describe: _____			

		YES	NO			YES	NO
7. Digestive/Intestinal/Liver Disorder		<input type="checkbox"/>	<input type="checkbox"/>				
Which family member(s) has a digestive system condition?				If Alcoholic Hepatitis - Do you currently have?			
_____				If no - How long since recovery?			
GERD/Gastroesophageal Reflux Disease/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>		_____			
Did symptoms abate/improve with drug therapy?	<input type="checkbox"/>	<input type="checkbox"/>		If Alcoholic Hepatitis - Any alcohol consumption?			
Are drugs you're taking prescribed by physician?	<input type="checkbox"/>	<input type="checkbox"/>		If Alcoholic Hepatitis - Normal liver function tests?			
Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers	<input type="checkbox"/>	<input type="checkbox"/>		Gall Bladder Disease/Cholelithiasis/Cholecystitis			
Have you had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>		Any stones in Gall Bladder or Common Bile Duct?			
If yes - Any recurrence since surgery?	<input type="checkbox"/>	<input type="checkbox"/>		Was it a single attack of symptoms?			
If yes - What type of surgery was done?				Has the gall bladder been removed?			
<input type="checkbox"/> Subtotal gastrectomy <input type="checkbox"/> Total gastrectomy				If yes - Date surgery done?			
<input type="checkbox"/> Other type of surgery				_____			
If yes - When was surgery (in MMYYYY)?	____/____/____			If no - Date of last attack of symptoms?			
If yes - Diagnosis of dumping syndrome?	<input type="checkbox"/>	<input type="checkbox"/>		_____			
If no - Any episodes of obstruction, any hospitalizations, or any hemorrhages?	<input type="checkbox"/>	<input type="checkbox"/>		Jaundice or hepatitis in the last 6 months?			
If no - Date last episode of symptoms:	____/____/____			<input type="checkbox"/>			
If no - More than one episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>		Hernia			
Crohn's Disease/Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>		Inguinal, Scrotal or Femoral hernia?			
Have you had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>		Has it been operated on?			
If yes - What kind of surgery was done?				If no, any symptoms from?			
<input type="checkbox"/> Partial bowel resection <input type="checkbox"/> Total bowel resection				If unoperated and symptomatic, are symptoms managed by medicine?			
If partial - Date last episode of symptoms?	____/____/____			<input type="checkbox"/>			
If total - Date surgery done?	____/____/____			Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis			
If no surgery done - How many episodes of symptoms?				<input type="checkbox"/>			
<input type="checkbox"/> Single <input type="checkbox"/> Multiple				<input type="checkbox"/> Currently under treatment			
If single-Does diet & meds control symptoms?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Single Attack in the past			
If yes - Date of last episode of symptoms?	____/____/____			<input type="checkbox"/> Multiple Attacks in the past			
If no - When was last episode of symptoms?	____/____/____			If multiple date of last episode of symptoms:			
If multiple - Date last episode of symptoms?	____/____/____			_____			
Gastrointestinal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>		Colon Polyps/Rectal Polyps			
When was last bleeding episode (in MMYYYY)?	____/____/____			Benign?			
Are you currently under treatment?	<input type="checkbox"/>	<input type="checkbox"/>		Recurrent?			
Diverticulitis/Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>		Have you had surgery on?			
Do you currently have symptoms from this?	<input type="checkbox"/>	<input type="checkbox"/>		Pancreatitis			
Have you had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>		Is condition chronic or acute?			
If yes - Did patient get colostomy?	<input type="checkbox"/>	<input type="checkbox"/>		Any history of alcohol abuse?			
If yes - Which kind? <input type="checkbox"/> permanent <input type="checkbox"/> temporary				Any subsequent liver disease?			
All affected portion with diverticula removed?	<input type="checkbox"/>	<input type="checkbox"/>		Single episode of pancreatitis?			
If yes - Date surgery was done?	____/____/____			Does patient currently have?			
If all affected portion not removed - Date of last treatment?	____/____/____			If no, date of last episode of symptoms:			

If no surgery - Single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>		Ulcerative Colitis/Chronic Inflammation of Colon			
If yes - Date of episode (in MMYYYY)?	____/____/____			Single or multiple episodes?			
If no - Date last episode of symptoms?	____/____/____			Have you had surgery for condition?			
				If yes - Does patient have permanent ostomy?			
				If yes - date surgery done (in MMYYYY)?			
				If yes - Is patient on prescription medications?			
				If no - Is condition under control?			
				If no - Is patient taking steroid medication?			
				If no - date last episode of symptoms:			

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

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

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

	YES	NO
10. Nervous System/Brain Disorder/Headache	<input type="checkbox"/>	<input type="checkbox"/>
Which family member(s) has a nervous system condition?		
Headaches/Migraines/Cluster Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Characterization of severity & frequency of headaches (pick one)		
<input type="checkbox"/> Mild, less than 5/year	<input type="checkbox"/> Severe, > 10/year	
<input type="checkbox"/> Moderate, 5 - 10/year	<input type="checkbox"/> Recent onset of severe HA	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Recently diagnosed?	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Do you: <input type="checkbox"/> currently have <input type="checkbox"/> recovered from		
If recovered from, are you wheelchair confined?	<input type="checkbox"/>	<input type="checkbox"/>
If recovered from, do you require cane, crutch or brace rather than a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Was there a loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how long was loss of consciousness?		
<input type="checkbox"/> < 1 hour <input type="checkbox"/> < 1 day <input type="checkbox"/> more than 1 day		
If < 1 hour-Any residual problems post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
If < 1 day - give date of recovery: _____/_____/_____		
If < 1 day-Any residual problems post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis/Encephalomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If no, any residual complications post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
If no, how long since recovery (in MMYYYY)? _____/_____/_____		
Alzheimer's Disease/Senility/Dementia	<input type="checkbox"/>	<input type="checkbox"/>
How much independence does individual have?		
<input type="checkbox"/> Total independence		
<input type="checkbox"/> Requires some assistance with self care		
<input type="checkbox"/> Totally dependent for self care		
Heat Exhaustion/Heat Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Which diagnosis? <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Heat Stroke		
Single episode?	<input type="checkbox"/>	<input type="checkbox"/>
If no, date of last episode: _____/_____/_____		

	YES	NO
Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>
Has the individual had surgery to correct?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, any complications/ other neurological problems post-op?	<input type="checkbox"/>	<input type="checkbox"/>
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>
Is condition under control with medication?	<input type="checkbox"/>	<input type="checkbox"/>
When was diagnosis made (in MMYYYY)? _____/_____/_____		
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>
Is disease progressing?	<input type="checkbox"/>	<input type="checkbox"/>
If no, are symptoms mild?	<input type="checkbox"/>	<input type="checkbox"/>
Neuroma/Abnormal Nerve Growth	<input type="checkbox"/>	<input type="checkbox"/>
Is growth benign?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was surgery (in MMYYYY)? _____/_____/_____		
If no, when was recovery (in MMYYYY)? _____/_____/_____		
Is the diagnosis Morton's Neuroma?	<input type="checkbox"/>	<input type="checkbox"/>
ALS/Amyotrophic Lateral Sclerosis/ Lou Gehrig's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis/Hemiplegia/Paraplegia	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's Chorea	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Viral Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Creutzfeldt-Jakob Disease	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Motor Neuron Disease	<input type="checkbox"/>	<input type="checkbox"/>
Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia/Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
Other disorder of the nervous system	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
11. Epilepsy/Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Which family member(s) has epilepsy or seizure disorder?		
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Do you know what type of seizure has been diagnosed?		
If yes, what is seizure type? <input type="checkbox"/> Febrile		
<input type="checkbox"/> Petit Mal <input type="checkbox"/> Jacksonian		
<input type="checkbox"/> Grand Mal <input type="checkbox"/> Focal		
Is another disease condition causing seizures?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe condition: _____		

	YES	NO
Are seizures increasing in frequency?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient taking medications?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are seizures controlled by medication?	<input type="checkbox"/>	<input type="checkbox"/>
When was the last seizure (in MMYYYY)? _____/_____/_____		
Other seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe condition: _____		

	YES	NO
12. Mental/Psychiatric Condition/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Which family member(s) has a mental health condition?		
Affective Disorders	<input type="checkbox"/>	<input type="checkbox"/>
What is diagnosis (pick one below)?		
<input type="checkbox"/> Obsessive Compulsive Disorder (OCD)		
<input type="checkbox"/> Panic Disorder <input type="checkbox"/> Agoraphobia		
<input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Neuroses		
Is treatment effective?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date treatment become effective? _____/_____/_____		
What is characterization of severity of symptoms?		
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Schizophrenia/Paranoia	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Major Depression/Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
When was diagnosis made (in MMYYYY)? _____/_____/_____		
Eating Disorder/Bulimia/Anorexia	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
When was recovery (in MMYYYY)? _____/_____/_____		
Attention Deficit Disorder/ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
What is characterization of severity of symptoms?		
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Are symptoms controlled by medication?	<input type="checkbox"/>	<input type="checkbox"/>
Situational Depression/Mild Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Is only current treatment prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>
Other mental health/psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO		YES	NO
13. Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
Which family member(s) has history of drugs or alcohol abuse?					
_____			Is the patient currently using?	<input type="checkbox"/>	<input type="checkbox"/>
What is patient dependent on?			If not currently using, when did the patient last use drugs/alcohol (in MMYYYY)?		____/____
<input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana					
<input type="checkbox"/> Drugs besides marijuana and alcohol					

	YES	NO		YES	NO
14. Back or Neck Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Which family member(s) has a back or neck condition?					
_____			Ankylosing Spondylitis/Spondylolisthesis	<input type="checkbox"/>	<input type="checkbox"/>
Cervical (Neck) or Thoracic (Mid Back) or Lumbar (Low Back)			Have you had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
Disc Herniation or Protrusion	<input type="checkbox"/>	<input type="checkbox"/>	If no, is condition symptomatic, requiring treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Strain/Whiplash/Muscle Spasm	<input type="checkbox"/>	<input type="checkbox"/>
Have you had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>	Are you under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, any subsequent problems post-op?	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica/Radiculitis/Radiating pain to legs or arms	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date of surgery (in MMYYYY)?		____/____	Does patient have any neurological defects?	<input type="checkbox"/>	<input type="checkbox"/>
If no surgery was done, have you recovered?	<input type="checkbox"/>	<input type="checkbox"/>	Is patient currently under treatment for?	<input type="checkbox"/>	<input type="checkbox"/>
If you have recovered, date of recovery?		____/____	Are episodes recurrent?	<input type="checkbox"/>	<input type="checkbox"/>
Are you totally disabled from condition?	<input type="checkbox"/>	<input type="checkbox"/>	When was last episode (in MMYYYY)?		____/____
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Spinal deformities/Scoliosis/Lordosis	<input type="checkbox"/>	<input type="checkbox"/>
Are you under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>	Has patient had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
If not in current treatment, date of last episode?		____/____	If surgery, any continuing problems post-op?	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Fractures	<input type="checkbox"/>	<input type="checkbox"/>	If surgery was done, date of surgery?		____/____
Any lingering neurological defects?	<input type="checkbox"/>	<input type="checkbox"/>	If no surgery, are you currently under treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Was fracture a compression fracture?	<input type="checkbox"/>	<input type="checkbox"/>	If you are currently under treatment, is condition?		
When was last treatment (in MMYYYY)?		____/____	<input type="checkbox"/> Mild or moderate <input type="checkbox"/> Severe		
Spinal Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	If no current treatment, date of last treatment?		____/____
Have you had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida/Myelocoele	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, give date of surgery:		____/____	Has patient had surgery for condition?	<input type="checkbox"/>	<input type="checkbox"/>
			If Yes, any residual neurological defects?	<input type="checkbox"/>	<input type="checkbox"/>
			Other back/neck disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Please describe: _____		

	YES	NO		YES	NO
15. Arthritis/Bone/Joint Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Which family member(s) has bone/joint disease/disorder/arthritis?					
_____			Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
Kind of arthritis do you have?			Paget's disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Degenerative <input type="checkbox"/> Osteoarthritis			Do you have a single affected area?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypertrophic <input type="checkbox"/> Chronic proliferative			Was the disease an incidental finding?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Senile <input type="checkbox"/> Arthritis deformans			Ligament tears/Torn Meniscus/Osteochondritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Juvenile Rheumatoid <input type="checkbox"/> Psoriatic			Has the patient had surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adult Rheumatoid <input type="checkbox"/> Chondrocalcinosis			If surgery, date of surgery:		____/____
<input type="checkbox"/> Atrophic <input type="checkbox"/> Septic			Bone dislocation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acute Infectious			Was the dislocation (choose one, below)?		
Is condition asymptomatic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Congenital hip <input type="checkbox"/> Patella (kneecap)		
If symptomatic, date of first onset of symptoms:		____/____	<input type="checkbox"/> Shoulder <input type="checkbox"/> Knee (not kneecap)		
Is more than one joint affected?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip-traumatic <input type="checkbox"/> Other joint-traumatic		
If no, is the joint a hip or knee?	<input type="checkbox"/>	<input type="checkbox"/>	Was there a single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a hip/knee replacement?	<input type="checkbox"/>	<input type="checkbox"/>	Does the patient currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If you had surgery, date it was done:		____/____	Has the patient had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
Characterization of disease progression/degree of disability			Dislocation was:		
<input type="checkbox"/> Mild, Minimal <input type="checkbox"/> Moderate to Severe			<input type="checkbox"/> Unilateral/one sided <input type="checkbox"/> Bilateral/both sides		
Is there a joint infection?	<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture	<input type="checkbox"/>	<input type="checkbox"/>
If yes, any bony involvement with infection?	<input type="checkbox"/>	<input type="checkbox"/>	Has treatment been completed?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is patient being currently treated?	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
If no, when was treatment completed:		____/____	Was the fracture? <input type="checkbox"/> Union <input type="checkbox"/> Non-Union		
Osteomyelitis/Bone Infection/Bone Abscess	<input type="checkbox"/>	<input type="checkbox"/>	Was the fracture of?		
Was there only a single episode?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg/hip/foot <input type="checkbox"/> Arm/hand/shoulder <input type="checkbox"/> Other bone		
Involved joint/bone was: <input type="checkbox"/> Major joint/bone <input type="checkbox"/> Minor joint/bone			Rotator cuff tear	<input type="checkbox"/>	<input type="checkbox"/>
Under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient had surgery on?	<input type="checkbox"/>	<input type="checkbox"/>
If no, date treatment completed:		____/____	If yes, date of surgery:		____/____
Bursitis/Tennis Elbow/Tendonitis/Synovitis	<input type="checkbox"/>	<input type="checkbox"/>	Date of original injury:		____/____
Was there only a single episode of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>			
Under current treatment for?	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
15. Arthritis/Bone/Joint Disorder (Continued)					
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Gout/Gouty Arthritis/Hyperuricemia	<input type="checkbox"/>	<input type="checkbox"/>
Is underlying cause known for condition?	<input type="checkbox"/>	<input type="checkbox"/>	Characterization of number of attacks?		
If yes, please describe cause for condition below:			<input type="checkbox"/> Few <input type="checkbox"/> Frequent		
_____			Are attacks well controlled by medication/diet?	<input type="checkbox"/>	<input type="checkbox"/>
Any symptoms from?	<input type="checkbox"/>	<input type="checkbox"/>	Other bone/joint disorder	<input type="checkbox"/>	<input type="checkbox"/>
Any subsequent fractures?	<input type="checkbox"/>	<input type="checkbox"/>	Please describe disorder: _____		
Does the patient take steroids for condition?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
	YES	NO		YES	NO

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

	YES	NO		YES	NO
17. Cancer/Tumors/Cysts					
Which family member(s) has a tumor, cancer or cyst?	<input type="checkbox"/>	<input type="checkbox"/>	Was the treatment surgery alone?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Cyst?	<input type="checkbox"/>	<input type="checkbox"/>	If NO, date treatment completed: _____/____/____		
Please describe: _____			Is the cancer metastatic?	<input type="checkbox"/>	<input type="checkbox"/>
Has the cyst been removed?	<input type="checkbox"/>	<input type="checkbox"/>	Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Tumor?	<input type="checkbox"/>	<input type="checkbox"/>	Lipoma/Adipose Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Was tumor confirmed benign by biopsy?	<input type="checkbox"/>	<input type="checkbox"/>
Is the cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>	Has the tumor been removed?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, have you had bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>			
If YES, are you bone marrow transplant candidate?	<input type="checkbox"/>	<input type="checkbox"/>			
What was stage of tumor?					
<input type="checkbox"/> Stage I <input type="checkbox"/> Stage IIA <input type="checkbox"/> Stage IIB					
<input type="checkbox"/> Stage IIIA <input type="checkbox"/> Stage IIIB <input type="checkbox"/> Stage IV					

	YES	NO		YES	NO
17. Cancer/Tumors/Cysts (Continued)					
Basal Cell/Squamous Cell Skin Cancer					
Was tumor? <input type="checkbox"/> Basal Cell <input type="checkbox"/> Squamous Cell	<input type="checkbox"/>	<input type="checkbox"/>			
Was tumor localized, & no lymph node involvement?	<input type="checkbox"/>	<input type="checkbox"/>			
Has there been any recurrence?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
What kind of treatment was done (choose one of following)?					
<input type="checkbox"/> Mohs Micrographic surgery <input type="checkbox"/> Radiation therapy					
<input type="checkbox"/> Simple excision <input type="checkbox"/> Carbon dioxide laser					
<input type="checkbox"/> Electrodessication/curettage <input type="checkbox"/> Topical fluorouracil					
<input type="checkbox"/> Cryosurgery <input type="checkbox"/> All others					
If no current treatment, date treatment completed: ___/___/___					
Ovarian Cancer					
What was stage of the tumor?	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV					
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
If no current treatment, date treatment completed: ___/___/___					
Is the cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>			
Has patient had a bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient a bone marrow transplant candidate?	<input type="checkbox"/>	<input type="checkbox"/>			
Is the cancer metastatic?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>			
Prostate Cancer					
Is the cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>			
Has cancer spread to other organs/organ systems?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
If no current treatment, date treatment completed: ___/___/___					
What was stage of the tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Stage A <input type="checkbox"/> Stage B <input type="checkbox"/> Stage C <input type="checkbox"/> Stage D					
Did patient have only surgery or surgery with other treatments?	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Surgery alone <input type="checkbox"/> Surgery & other treatments					
Any post-surgical complications?	<input type="checkbox"/>	<input type="checkbox"/>			
Is the cancer metastatic?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>			
Cervical Cancer					
Is the cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>			
What was stage of the tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV					
Was hysterectomy only done and/or radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Surgery alone <input type="checkbox"/> Surgery & Radiation <input type="checkbox"/> Radiation alone					
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
If no current treatment, date treatment completed: ___/___/___					
Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>			
Colon/Rectal Cancer					
Is the cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>			
What was stage of the tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV					
Was treatment surgery alone, or surgery and/or other treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Surgery alone <input type="checkbox"/> Surgery & other treatments					
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
If no current treatment, date treatment completed: ___/___/___					
Colon/Rectal Cancer (continued)					
Is cancer in remission?	<input type="checkbox"/>	<input type="checkbox"/>			
Is the cancer metastatic?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>			
Leukemia/Chronic Lymphocytic Leukemia (CLL)/Acute Lymphocytic Leukemia (ALL)/Chronic Myelogenous Leukemia (CML)/Acute Myeloid Leukemia (AML)/Acute Non Lymphocytic Leukemia (ANLL)					
Do you know kind of Leukemia diagnosed(choose one below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CLL <input type="checkbox"/> ALL <input type="checkbox"/> CML <input type="checkbox"/> AML <input type="checkbox"/> ANLL					
Date leukemia was diagnosed: ___/___/___					
What was stage of the tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV <input type="checkbox"/> Refractory					
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
If no current treatment, date treatment completed: ___/___/___					
Has the patient had a bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>			
If no, is bone marrow transplant considered?	<input type="checkbox"/>	<input type="checkbox"/>			
Has the patient had chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>			
Has the patient had radiation?	<input type="checkbox"/>	<input type="checkbox"/>			
Is the cancer in remission?	<input type="checkbox"/>	<input type="checkbox"/>			
Date cancer went into remission: ___/___/___					
Is patient receiving post-remission chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>			
Was treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chemotherapy & Radiation					
Has the patient had a relapse or recurrence?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>			
Lymphoma/Hodgkin's disease/Non-Hodgkin's Lymphoma					
Lymphoma type?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hodgkin's <input type="checkbox"/> Other type Lymphoma <input type="checkbox"/> Non-Hodgkin's <input type="checkbox"/> Don't Know					
What was stage of the tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV					
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
If no current treatment, date treatment completed: ___/___/___					
Is cancer in remission?	<input type="checkbox"/>	<input type="checkbox"/>			
Is cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>			
Melanoma					
What was stage of the tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV					
Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
If no current treatment, date treatment completed: ___/___/___					
Is cancer in remission?	<input type="checkbox"/>	<input type="checkbox"/>			
Is cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>			
Was treatment surgical excision alone?	<input type="checkbox"/>	<input type="checkbox"/>			
Was there only a single lesion?	<input type="checkbox"/>	<input type="checkbox"/>			
Was skin grafting necessary?	<input type="checkbox"/>	<input type="checkbox"/>			
Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
17. Cancer/Tumors/Cysts (Continued)					
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Is cancer recurrent?	<input type="checkbox"/>	<input type="checkbox"/>
What kind of Lung cancer was diagnosed?	<input type="checkbox"/>	<input type="checkbox"/>	Is cancer in remission?	<input type="checkbox"/>	<input type="checkbox"/>
Pick from:			Is patient under current treatment?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Large or Giant cell	<input type="checkbox"/> Squamous cell		If no current treatment, date treatment completed: _____/_____/_____		
<input type="checkbox"/> Adeno CA	<input type="checkbox"/> Oat Cell		What was treatment (pick one below)?		
<input type="checkbox"/> Adenosquamous	<input type="checkbox"/> Intermediate Cell		<input type="checkbox"/> Surgery	<input type="checkbox"/> Other Chemotherapy, not Taxol	
<input type="checkbox"/> Non Small Cell	<input type="checkbox"/> Mixed Cell		<input type="checkbox"/> Radiation	<input type="checkbox"/> Chemotherapy and Radiation	
What was stage of the tumor?	<input type="checkbox"/> Small Cell		<input type="checkbox"/> Taxol Chemotherapy	<input type="checkbox"/> Untreated	
<input type="checkbox"/> Stage 0	<input type="checkbox"/> Stage IV		Is patient under hospice care?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stage I	<input type="checkbox"/> Limited		Other type of cancer/tumor:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stage II	<input type="checkbox"/> Extensive		Please describe condition below: _____		
<input type="checkbox"/> Stage III			_____		

	YES	NO		YES	NO
18. HIV/AIDS/ARC Autoimmune Disease					
Which family member(s) has HIV, AIDS or autoimmune disease?	<input type="checkbox"/>	<input type="checkbox"/>	ARC (AIDS related complex)	<input type="checkbox"/>	<input type="checkbox"/>
_____			Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
HIV (human immunovirus)	<input type="checkbox"/>	<input type="checkbox"/>	Please describe condition: _____		
AIDS (acquired immune deficiency syndrome)	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
19. Any other Illness, Disease or Injury					
Which family member(s) has another type of disease condition, disorder or injury?	<input type="checkbox"/>	<input type="checkbox"/>	As a result of injury/illness have you had:	<input type="checkbox"/>	<input type="checkbox"/>
_____			Bone or skin Graft(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Other Disease/Disease Condition/Disorder/Injury not previously described	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe other condition: _____			Loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Loss or surgical removal of organ/limb?	<input type="checkbox"/>	<input type="checkbox"/>
_____			If yes, please describe: _____		
_____			_____		
_____			_____		
