



Health History Questionnaire

For: Resurrection Health Care Physicians

This form must be completed for each applicant and dependent. Please complete all sections and write legibly so your application can be processed without delay. Questions left unanswered or incomplete may delay or prevent processing of your request for coverage.

Section 1:

Name of Applicant: _____

Gender: F M Relationship to Primary Applicant: Self Spouse Child

Have you used tobacco products in the last 12 months? Yes No

Date of Birth: ____/____/____ Height: _____ Weight: _____

Have any blood relatives died before age 65? Yes No

Cause of Death: _____ Relationship: _____

Section 2: Applicant completes all of the following health questions. Any "Yes" answers (except to Question A) should be explained below. Please check the appropriate box(es).

- A. Are you currently in good health and free from treatment for any condition? Yes No
- B. Have you been diagnosed, or are you aware of, or are you currently pregnant? Yes No
- C. Have you been disabled for more than a total of 15 days within the last 12 months? Yes No
- D. Have you been confined to a hospital, skilled nursing home, rehabilitation facility, or other medical care facility within the last 12 months? Yes No
- E. Within the last 3 years have you been advised by a medical professional to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition? Yes No
- F. Have you ever been treated for, or been told that you had:
 - 1. High blood pressure, heart disease, stroke, hypertension, high cholesterol, heart attack, aneurysm, angioplasty, coronary bypass, hemophilia, or other disease of the circulatory system? Yes No

2. Ulcer, appendicitis, hernia, Crohn's disease, colitis, kidney stones, renal failure, other kidney problems, gallstones, hepatitis, cirrhosis, other problems of the liver, acid reflux, GERD, or other disease of the digestive system? Yes No
3. Tumors, malignant or benign, leukemia, or any other cancer? Yes No
4. Prostate, menstrual disorder or other disease of the genitourinary system Yes No
5. Chronic respiratory problems, asthma, emphysema, chronic bronchitis, COPD, cystic fibrosis, or other disease of the respiratory system? Yes No
6. Depression, neurosis, eating disorder, other mental and nervous disorders or alcohol or drug dependency? Yes No
7. Autism, ADD, ADHD, Alzheimer's disease, multiple sclerosis, epilepsy, seizures, or other brain or neurological disorders? Yes No
8. Arthritis, rheumatism, fractures, lupus, joint repair or replacement, back, spine or other musculoskeletal disorders? Yes No
9. Diabetes, or other metabolic or endocrine disorders? Yes No
10. Disorder of the blood - Disorder of the blood includes: all conditions of the blood presently recognized as disorders, both primary disorders of the blood (e.g. anemia, polycythemia, leukopenia, leukocytosis, clotting disorders, platelet disorders, immune disorders whether congenital or acquired, disorders of gammaglobulin) and disorders that reflect other disease processes (e.g. infections, malignancies, sources of blood loss, biliary tract disease). Yes No
11. Have you ever been treated/diagnosed by a medical professional for AIDS, tested positive for HIV, immune system disorders or blood disorders? Yes No
12. Skin or dermatological disorders such as acne, psoriasis, burns, skin cancer, keloids requiring plastic surgery? Yes No
13. Disorder of the eyes (other than vision impairment), ears, nose, or throat? Yes No
14. Down's Syndrome, cerebral palsy, or other congenital defects or development disorders? Yes No
15. Impotence, sexually transmitted diseases, uterine fibroids, breast implants, abnormal pap test, endometriosis, or other reproductive or genital disorders? Yes No
16. Cosmetic or reconstructive surgery or revisions within the last 5 years? Yes No
17. Any other disorders, diseases, ailments or impairments? Yes No

Please provide the information requested. You can attach a separate sheet if necessary. Be sure to sign and date.

Condition, Type of Treatment	Date	Name and Address of Physician and Hospital	Results (ongoing or degree of recovery)
Is the treatment described above continuing? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date treatment was no longer required: _____/_____/_____	

G. Do you currently take medication(s)?..... Yes No

Please provide the information requested. You can attach a separate sheet if necessary. Be sure to sign and date.

Medication Name	Dosage	Dates Taken	Prescribing Physician
1.			
2.			
3.			
4.			
5.			
6.			

Section 3:

Name and Address of Primary Physician: _____

Date last seen by Physician: ____/____/____ Reason for visit: _____

Section 4:

I agree that, to the best of my knowledge and belief, all statements and answers to the questions contained in this application are true. I agree that they will be a basis of the issuance of coverage.

By signing this form I authorize Physicians' Benefits Trust Life Insurance Company to gather individually identifiable health information, including medical records (excluding psychotherapy notes), lab records, and prescription records from sources including but not limited to physicians, clinics, hospitals, pharmacy benefit managers, and health plans. This information will be used for the purpose of evaluating and underwriting my insurance application. This authorization is valid until the time I receive a final determination on my application for coverage. I may revoke this authorization by notifying Physicians' Benefits Trust Life Insurance Company in writing. I understand that this information may be subject to re-disclosure, and once re-disclosed, may no longer be subject to federal rules governing privacy. I understand that signing this form is voluntary and that I need not sign it to assure eligibility.

Signature of Applicant: _____

Date: ____/____/____

Signature of Dependent (if 18 years of age or older): _____

Date: ____/____/____

Return your completed Health History Questionnaire to:

PBT Insurance Office
200 E. Randolph Street • 5th Floor
Chicago, IL 60601

If you have any questions:

Physicians and their office staff please call: **1-800-621-0748**

Dentists and their office staff please call: **1-866-898-0926**

You can also fax your questions to:

1-312-381-2795

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