

Health Questionnaire

Name:

Date of Birth:

Present Height:

Present Weight:

Have you used tobacco in the past year?

Mailing Address :

City:

State:

Zip code:

Email:

Home or Business Phone:

Gender Male _____ Female

Marital Status:

Name of spouse or child(ren) :

Are they to be covered?

Date of Birth(s) :

Have any of the applicants used tobacco in the past year?

Insurance

Current Health Insurance Company:

Name of Responsible Person:

Type of Coverage:

Birthdate of Responsible Person: (self, spouse, parent, group)

Health History

Please check if you've had problems with any of the following:

- Heart
- Lungs
- Kidney
- Stomach/Gastrointestinal
- Eyes/Ears
- Blood
- Anemia
- Fainting/Dizziness
- Rheumatic Fever

- Arthritis
- Tuberculosis
- High Blood Pressure
- Cancer
- Epilepsy
- Migraines
- Mental Disorder/Illness

If you checked any of the above, please give details, including whether or not the problem is chronic/on-going:

Are you taking any medications regularly? Yes
 No

If yes, please list name and dosage of medications:

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