MEDICAL HISTORY QUESTIONNAIRE

(to be completed by employee)

Date: ______________

Horizon Benefits Group needs your help in reviewing your employer's Group Insurance Program. The information requested will enable us to properly evaluate your group. Please complete the following. Our insurance consultant will review the answers to these questions **confidentially.** *Thank you for your assistance*.

____________________	___	__________	___ft.___in.	______
Employee Name	**Sex**	**Date of Birth**	**Height**	**Weight**

_________	___ft.___in.	_______	_________
Spouse Age	**Height**	**Weight**	**# of Children**

I anticipate enrolling in the plan as:
- ____ **Employee Only**
- ____ **Employee & Spouse**
- ____ **Employee & Children**
- ____ **Employee, Spouse & Children**

Have you or any member of your family to be insured, been diagnosed, received treatment or currently receiving treatment for any of the following conditions within the **past 10 years** (please complete each question):

1. Cancer or tumor? ☐Yes ☐ No
2. Diabetes? ☐Yes ☐ No
3. Alcohol/illicit drug use or abuse? ☐Yes ☐ No
4. Liver disease/Cirrhosis/Hepatitis? ☐Yes ☐ No
5. Lung or respiratory conditions? (Asthma) ☐Yes ☐ No
6. Gall bladder, liver, stomach or intestines? ☐Yes ☐ No
7. Immune System? (Aids) ☐Yes ☐ No
8. Psychological conditions? (Depression) ☐Yes ☐ No
9. Heart conditions/hypertension/stroke? ☐Yes ☐ No
10. Bones/Joints/Muscles/Arthritis? ☐Yes ☐ No
11. Kidney/urinary tract/bladder (stones, infection)? ☐Yes ☐ No
12. Neurological conditions? ☐Yes ☐No
13. Other? ☐Yes ☐No
14. Have any claims over $5,000 been billed in the last 18 months? ☐Yes ☐No
15. Are there any ongoing disabilities? ☐Yes ☐No
16. Have you, your spouse and any children been in a hospital, surgi-center as an inpatient or outpatient? ☐Yes ☐No
17. Are you or your spouse/dependent currently pregnant? ☐Yes ☐No

EXPLANATION SECTION: Explain any "Yes" below (attach additional sheet if necessary)

Question #	Name/Age	Diagnosis	Treatment	Date Diagnosed	Date of Last Treatment

Have you, your spouse, or any dependent been advised of a condition that will require medical treatment in the next 12 months? ❑Yes ❑ No If Yes, give date and details:

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List all the medications that you, your spouse, or any dependent to be insured has had prescribed in the last 12 months.

Medication	**Dosage**	**Frequency**	**Date of Last Refill**	**For What Ailment**