

# Medical History Questionnaire

Insurance Specialties I.I.C  
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[www.insspecial.com](http://www.insspecial.com)

Employer Name : \_\_\_\_\_  
Employee Name : \_\_\_\_\_  
D.O.B. : \_\_\_\_\_  
Name of Employee or Dependent with Medical Condition : \_\_\_\_\_

## Health History - Please answer all questions in this section

1. Height : \_\_\_\_\_ Weight : \_\_\_\_\_
2. Diagnosis : \_\_\_\_\_ Date of Diagnosis : \_\_\_\_\_
3. Date of most recent physician visit : \_\_\_\_\_  
Physician name/address/phone number : \_\_\_\_\_  
\_\_\_\_\_
4. Have you been advised to seek a referral from a specialty provider? \_\_\_\_\_  
If yes, please explain (include all physician names and addresses) : \_\_\_\_\_  
\_\_\_\_\_
5. Any hospital visits? \_\_\_\_\_ If yes, when and for what reason : \_\_\_\_\_  
\_\_\_\_\_
- Inpatient  Urgent Care/ER
6. Any surgeries done or anticipated? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_
7. Do you use tobacco?  No  Yes If yes, amount and frequency : \_\_\_\_\_
8. Are you on any medication?  No  Yes If yes, name(s) and dosage(s) : \_\_\_\_\_  
\_\_\_\_\_
9. Do you have elevated cholesterol or take medication for elevated cholesterol? \_\_\_\_\_  
If yes, list most recent reading and medication : \_\_\_\_\_
10. Did you test positive for Hepatitis in the past 5 years? \_\_\_\_\_ If yes, which type?  A  B  C  
Describe treatment : \_\_\_\_\_
11. Did you receive follow up care for cancer in the last 5 years? \_\_\_\_\_  
If yes, please explain ( chemotherapy/radiation, preventative meds): \_\_\_\_\_  
\_\_\_\_\_

Spouse Name : \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Ht. : \_\_\_\_\_ Wt. : \_\_\_\_\_

Dependents:

Name	D.O.B.
_____	_____
_____	_____
_____	_____
_____	_____

In addition to the above health history, please complete applicable diagnosis-specific sections on the next page. If no specific condition exists, proceed to last question and signature area.



**High Blood Pressure (Hypertension) :**

When Diagnosed? \_\_\_\_\_ When was your last blood pressure reading? \_\_\_\_\_

Blood Pressure Reading : \_\_\_\_ / \_\_\_\_ List all medications and dosages : \_\_\_\_\_

How often do you have your blood pressure checked by a physician? \_\_\_\_\_

Any other testing (e.g. EKG, Treadmill)? \_\_\_\_\_

Date : \_\_\_\_\_ Results : \_\_\_\_\_

Any surgeries completed or recommended ?  Yes  No If yes, please explain : \_\_\_\_\_

Any history of stroke/heart attack? Yes No When? \_\_\_\_\_

Treatment? \_\_\_\_\_

List any other condition, treatment, disability, and/or deformity not already listed :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare all statements contained in this entire form are true and correct and that no material information has been withheld/omitted. I agree that no coverage/insurance will be effective until the date specified in the summary plan description/certificate of insurance.

\_\_\_\_\_  
Signature of Individual with medical condition(s) or legal guardian      Date

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