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Lungs or Respiratory System

Lungs or Respiratory System

Was a final diagnosis given regarding your Lung/Respiratory condition?

If yes, what was the diagnosis of your condition?

Date of diagnosis for this condition

Treatment (Medication)?

If yes, name of medication(s)

Date medication was last taken

Surgery?

If yes, date of surgery

Type of surgery performed

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history

Ever had a pulmonary function test to measure how well your lungs take in and release air?

If yes, was it normal?

If no, what was the abnormality?

Ever had a chest x-ray?

Was it normal?

If no, what was the abnormality?

Ever required use of oxygen?

If yes, need date

Ever used tobacco products?

If yes, date last used?

Asthma

Date of diagnosis for your condition

Treatment (Medication)?

If yes, name of medication(s)?

Date medication was last taken?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history

Ever had a pulmonary function test to measure how well your lungs take in and release air?

If yes, was it normal?

If no, what was the abnormality?

Ever had a chest x-ray?

Was it normal?

If no, what was the abnormality?

Ever required use of oxygen?

If yes, need date

Ever used tobacco product?

If yes, date last used

Ever been hospitalized for asthma

If yes, how many days?

Date hospitalized?

Ever been to the ER for asthma?

If yes, need date?

Coronavirus/COVID-19

Date Tested?

Test Results?

Treatment (Medication)?

Did it require hospitalization?

Was recovery complete with no residual impairment or ongoing symptoms?

Name of Doctor or Medical Facility with complete medical records?

Allergies

Date of diagnosis for this condition?

Pneumonia

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medication?

Date medication was last taken?

Did it require hospitalization?

If yes, how many days?

Was recovery complete with no residuals, impairments or ongoing symptoms ?

If no, need details

Chronic Bronchitis

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication was last taken?

Name and address of the doctor that will have your medical records including this history?

Ever used tobacco products?

If yes, date last used?

Ever had a pulmonary function test to measure how well your lungs take in and release air?

If yes, was it normal?

If no, what was the abnormality?

Ever had a chest x-ray?

Was it normal?

If no, what was the abnormality?

Ever required use of oxygen?

If yes, need date

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Emphysema

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medication?

Date medication was last taken

Any ongoing symptoms, residuals or impairments?

If yes, need detail

Doctor's name and address that will have your medical records, including this medical history?

Ever had a pulmonary function test to measure how well your lungs take in and release air?

If yes, was it normal?

If no, what was the abnormality?

Ever had a chest x-ray?

Was it normal?

If no, what was the abnormality?

Ever required use of oxygen?

If yes, need date?

Ever used tobacco products?

If yes, date last used?

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Sleep Apnea

Date of diagnosis for this condition?

Have you ever been diagnosed with obstructive sleep apnea?

If yes, date of diagnosis?

Treatment (Medication)?

If yes, need name of medication(s)

Date medication last taken?

Do you currently use a C-Pap?

Have you ever been recommended to use a C-Pap?

Have you ever had a surgery to correct sleep apnea?

What type of surgery was performed?

Heart or Circulatory System

Heart or Circulatory System

What was the condition or diagnosis?

Date you were diagnosed or treated for this condition?

Treatment (Medication)?

If yes, name of medication(s)?

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Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor Name/Address that will have your medical records, including this medical history

Did you have an EKG performed?

Date of EKG?

If yes, was it normal?

Did you have any other heart related tests performed?

If yes, date of test(s)?

What test(s) were performed?

Were all the tests normal?

Coronary Artery Disease

Date of diagnosis of this condition?

Date of last treatment for this condition?

Congestive Heart Failure

Date of diagnosis of this condition?

Date of last treatment for this condition?

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High Blood Pressure

Date of diagnosis of this condition?

Have you been prescribed or taking medication for this condition?

If yes, name of medication(s) you are taking for this condition

Has the doctor changed your medication or dosage since the treatment was started?

If yes, what changes were made and why?

Date medication was changed?

Name of new medication(s)?

Do you know what your last blood pressure reading was?

If yes, need last reading

When blood pressure readings are taken at the doctor's office do they indicate to you they are normal and controlled?

Do you take your medication every day?

If no, did you discontinue on your own?

Did your doctor tell you to stop the medication?
Date of last EKG?

Results of last EKG?

Any history or diagnosis of the following?

- Chest Pain
- Heart Attack
- Coronary Artery Disease
- Heart Murmur
- Stroke/T.I.A
- Elevated lipids (cholesterol/triglycerides)
- Aneurysm

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Are you compliant with this medication?

Is your blood pressure under good control?

Name, address and telephone number of physician with these medical records?

Heart Attack

Date of diagnosis of this condition?

Date of last treatment for this condition?

Stroke

Date of diagnosis of this condition?

Date of last treatment for this condition?

Heart Murmur

Date of diagnosis for this condition?

Did doctor give a diagnosis of any of the following:

1. Physiological, Innocent or Functional?

2. Systolic?

3. Diastolic?

4. Organic?

5. Atrial Septal Defect?

6. Bicuspid Aortic Valve?

7. Patent Ductus Arteriosus?

8. Tetralogy of Fallot?

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9. Ventricular Septal Defect?

10. Aortic Insufficiency, Stenosis and/or Regurgitation?

11. Mitral Valve Prolapse, Insufficiency, Stenosis and/or Regurgitation?

12. Pulmonary Insufficiency, Stenosis and/or Regurgitation?

13. Tricuspid Insufficiency, Stenosis and/or Regurgitation?

14. Other: (Physiological, Innocent or Functional, Systolic, Diastolic, Organic, Atrial Septal Defect, Bicuspid Aortic Valve, Patent Ductus Arteriosus, Tetralogy of Fallot, Ventricular Septal Defect, Aortic Insufficiency, Stenosis and/or Regurgitation, Mitral Valve Prolapse, Insufficiency, Stenosis and/or Regurgitation, Pulmonary Insufficiency, Stenosis and/or Regurgitation, Tricuspid Insufficiency, Stenosis and/or Regurgitation, Other)

Need details

How is the heart murmur treated?

Have you taken any Treatment (Medication)?

Name of medication(s).

Has your medication or dosage been changed?

Date medication was changed?

What was the Reason for medication change?

Are you compliant with this medication?

If you are no longer taking medication, did the doctor advise you to discontinue?

Reason you were advised to discontinue?

Did you discontinue your medication on your own?

Reason you discontinued?

Do you take antibiotics prior to dental visits?

Have you ever had an Echocardiogram, Sonogram, EKG, CATH or other diagnostic testing?

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What test(s) were performed?

What was the date of the tests?

Were the tests normal, abnormal or unknown?

Do you have a copy of any of your tests? (

Will you email these copies to our office? Email to Newbusaps@ushealthgroup.com e-fax 1-800-232-2026 Or they can give us verbal permission to go into their electronic medical record portal and let us download the records. We need website, username and password.

What date did you last have any symptoms, such as heart racing, palpitations, irregular heartbeat, chest pain, fatigue or weakness?

What symptom(s) did they experience?

Have you ever been diagnosed with any other disorder of the heart and/or circulatory system?

Diagnosis of your condition

Date of diagnosis of this condition

How is this condition being treated?

Date of your last check up for this condition?

What were the results of your tests?

Did you have any recommendations advised by your doctor?

What recommendations were given?

Has doctor ever advised or recommended them to have any surgery for the heart murmur?

Date of surgery

What type of surgery was performed?

Was any surgery, treatment, or testing recommended and not performed?

What was recommended?

Why was it not performed?

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Is recovery complete with no residuals, impairments or ongoing symptoms?

Need details

Doctor's name and address that will have your medical records including this medical history

Mitral Valve Prolapse

Regarding your Mitral Valve Prolapse, what was the date of diagnosis?

Treatment (medications)?

Were you prescribed or are you taking any medication(s)?

List medication(s) name

Date medication started

Date medication last taken

Has your medication or dosage been changed?

If yes, date of medication change?

What was the change?

Reason for medication change?

Are you compliant with taking the medications?

If you are no longer taking medication, did the doctor advise you to discontinue?

If yes, date discontinued?

Reason you were advised to discontinue

Did you discontinue your medication on your own?

If yes, reason you discontinued?

Do you take antibiotics prior to dental visits?

Have you ever had an Echocardiogram, Sonogram, EKG, CATH or other diagnostic testing?

If yes, were the tests normal, abnormal or unknown?

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Date of test(s)?

What date did you last have any symptoms, such as heart racing, palpitations, irregular heartbeat, chest pain, fatigue or weakness?

What was the symptom from the list above?

Have you ever been diagnosed with any other disorder of the heart?

If yes, what was the diagnosis?

Date of diagnosis?

How is this condition treated?

Do you have a copy of any of your tests?

If yes, would you mind faxing or emailing a copy to our office?

Date of your last check up?

What were the results of your tests?

Any recommendations advised by your doctor?

If yes, what recommendations were given?

Have you ever been told that you have?

1. Barlow's Syndrome?
2. Floppy Valve syndrome?
3. Ballooning mitral valve syndrome?
4. Aortic regurgitation?
5. Aortic stenosis?
6. Mitral Insufficiency?
7. Mitral stenosis?
8. Pulmonary stenosis?

If yes to any of the above conditions, what was the date of diagnosis?

Have you had any surgery, advised or recommended to have any surgery for your heart murmur or heart valve disorder?

If yes, date of surgery?

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Type of surgery performed?

Any surgery or treatment recommended that has not been performed?

If yes, what was recommended?

Is recovery complete with no residuals, impairments, or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Irregular Heartbeat

Regarding your Irregular Heart Beat, what was the date of diagnosis of this condition?

Treatment (medication)

Were you prescribed or are you taking any medication(s)?

List medication(s) name?

Date medication started?

Date last taken?

Has your medication or dosage been changed?

If yes, date of change?

Reason for change?

Are you compliant with taking the medications?

If you are no longer taking medication, did the doctor advise you to discontinue?

If yes, reason the doctor advised you to discontinue?

Did you discontinue on your own?

If yes, reason you discontinued?

Do you take antibiotics prior to dental visits?

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Have you ever had an Echocardiogram, Sonogram, EKG, CATH or other diagnostic testing?

If yes, what was the date of the tests?

What were the test results? Normal, abnormal or unknown

What date did you last have any symptoms, such as heart racing, palpitations, irregular heartbeat, chest pain, fatigue or weakness?

What was the symptom from the list above?

Have you ever been diagnosed with any other disorder of the heart?

If yes, what was the diagnosis?

Date of diagnosis?

How is this condition treated?

Do you have a copy of any of your tests?

Type of tests?

Date of tests?

Would you mind faxing or emailing a copy to our office?

Date of your last check up for this condition?

What were the results of your tests?

Did you have any recommendations advised by your doctor?

If yes, what recommendations were given?

Have you had any surgery, advised or recommended to have any surgery for your irregular heartbeat?

If yes, date of surgery?

Type of surgery performed?

Any surgery or treatment recommended that has not been performed?

If yes, what was recommended?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records, including this medical history

Did your doctor give you a diagnosis of any of the following?

1. Tachycardia/Arrythmia?
2. Paroxysma/Atria Tachycardia?
3. Ventricular Tachycardia?
4. Atrial Fibrillation?
5. Premature Ventricular Contractions?
6. Unknown?

Do you have a pacemaker?

Hyperlipidemia/Elevations of Cholesterol/Triglycerides

Date of diagnosis?

Have you been prescribed or taking any medications for this condition?

If yes, name of medication(s)?

Are you compliant with taking the medications?

If you are no longer taking medication, did the doctor advise you to discontinue?

If yes, reason the doctor advised you to discontinue?

Did you discontinue on your own?

If yes, reason you discontinued?

Is your condition under control using this medication?

Doctor's name and address that has this medical history

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Blood or Blood Forming Organs

Blood or Blood Forming Organs

Date of diagnosis of your condition?

What was the diagnosis of your condition?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was anemia secondary to another condition?

If yes, what was the condition?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Anemia

Type of Anemia?

1. Iron Deficiency?
2. Aplastic?
3. Hypoplastic?
4. Megaloblastic?
5. Pernicious?
6. Sickle Cell?
7. Other?

Date of diagnosis?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Was anemia secondary to another condition?

If yes, what was the condition?

Have you ever had a blood transfusion?

If yes, how many?

Dates of transfusion(s)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Hemophilia

Date of diagnosis?

Date of last treatment?

Blood Clots

Diagnosis/Location of Blood Clots?

Date of diagnosis?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Was the blood clot secondary to another condition?

If yes, what was the condition?

Surgery?

If yes, date of surgery?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Digestive

Stomach

What was the diagnosis or condition?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Esophagus

What was the diagnosis or condition?

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Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Intestines

What was the diagnosis or condition?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was a Colostomy performed?

If yes, need date

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Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Rectum

What was the diagnosis or condition?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Digestive System

What was the diagnosis or condition?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Ulcers

What type of ulcer? Stomach, intestinal, colon, rectum or anus?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Was your condition benign (non-cancerous) or malignant (cancerous)?

Was recovery complete with no residuals, impairments or ongoing symptoms

If no, need details

Have you ever had any bleeding/hemorrhaging due to the ulcer?

If yes, date?

Is this condition chronic, recurrent or with complications?

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If yes, needs details.

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If not, need details.

Doctor name / address that will have your medical records including this medical history?

Colitis

Was it Functional or Acute Colitis?

Was it Ulcerative Colitis?

Was it Crohn's Disease?

Date of diagnosis of your condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication was last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residual, impairments or ongoing symptoms?

If no, need details.

Doctor name/address that will have your medical records, including this medical history?

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Gastritis

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication was last taken?

Surgery?

IF yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details.

Doctor name/address that will have your medical records, including this medical history?

Crohn's Disease

Regarding Crohn's Disease, what was the date of diagnosis?

Last date of treatment?

Hernia

What was the location of your Hernia: Hernia, Inguinal or Umbilical?

Date of diagnosis for this condition?

Surgery?

If yes, date of surgery?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details.

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Hemorrhoids

Regarding hemorrhoids, what was the date of your diagnosis?

Treatment (medication)?

If yes, name of medication(s)?

Date medication was last taken?

Was any surgery, banding or injections performed?

If yes, date of procedure?

Are your hemorrhoids recurring?

Have you ever been recommended to have surgery or injections that have not yet been performed?

If yes, what type of treatment was recommended?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details?

Doctor's name and address that will have medical records, including this medical history?

Gallbladder Disease

Date of diagnosis for your condition?

What was your diagnosis or condition?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Liver

Diagnosis of your condition?

Date of diagnosis for this condition?

Treatment (medication)?

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If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Was liver disorder caused by alcohol use?

If yes, complete (alcohol drill down)

Was liver disorder caused by prescription drug use?

If yes, name of drug?

If yes, complete (drug drill down)

Have you ever been diagnosed with fatty liver, enlarged liver, liver cysts, or had an abnormal liver function test?

If yes, which condition?

Doctor's name and address that will have your medical records including this medical history

Cirrhosis

Date of diagnosis for your condition?

Date of last treatment?

Hepatitis

Type of hepatitis?

1. A?

2. B?
3. C?
4. D?
5. E?
6. G?

Date of diagnosis for this condition?

Was hepatitis alcohol induced?

If yes, complete (alcohol drill down)

Was hepatitis drug induced?

If yes, what type of drug(s)?

If yes, complete (drug drill down)

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history

Urinary System

Kidneys

Diagnosis of your condition?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Urinary System

Diagnosis of your condition?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Kidney Stones

Number of attacks?

- 1?
- 2?

- 3?
- 4?
- More than 4?

Date of each attack?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was a stent placed?

If yes, has the stent been removed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details
Doctor name/address that will have your medical records, including this medical history

Cystitis

Number of attacks?

- 1?
- 2?
- 3?
- 4?
- 5?

Date of each attack?

Was the diagnosis Interstitial Cystitis?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Have you ever had to use a catheter?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Urinary Incontinence

Diagnosis of your condition?

Cause of this condition?

Ever diagnosed with Cystocele or Prolapsed?

If yes, which condition?
Date of diagnosis of this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Urinary Tract Infections

Diagnosis of your condition?

Was the cause of this condition due to?

1. Cystocele?
2. Prolapsed Bladder?
3. Neurogenic Bladder?
4. Unknown?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

How many occurrences have you had?

Date(s) of each occurrence?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Have you ever had to use a catheter?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

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Pancreas

Endocrine System

Pancreas

Diagnosis of your condition?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Pancreatitis

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication was last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Was pancreatitis due to excessive alcohol use?
If yes, complete alcohol drill down
If no, did you doctor tell what caused the pancreatitis?
If yes, what was the cause?

Diabetes

Diagnosis of your condition?

- Type I?
- Type II?
- Insipidus?
- Mellitus or Gestational?

If Gestational, have you had any testing to confirm your blood sugar levels have returned to normal?
If yes, what were the results?
Date of test?
Date of diagnosis of this condition?
Treatment (medication)?
If yes, name of medication(s)?
Date medication was last taken?
If not on medication, is it controlled by diet/exercise?
Doctor's name/address that will have your medical records, including this medical history?

Sugar Glucose Intolerance / Impaired Fasting Glucose / Hyperglycemia

Was Diabetes diagnosed?

If yes, which type?

- Type 1?
- Type 2?
- Insipidus?
- Mellitus or Gestational?

Date of diagnosis of your condition?

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If Gestational, have you had any testing to confirm your blood sugar levels have returned to normal?

If yes, what were the results?

Date of test?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

If no, did your doctor advise you to discontinue the medication?

Do you know what your last blood sugar reading was?

If yes, what was your reading?

Do you know what your last hemoglobin A1C test showed?

If yes, what were the results of your test?

Doctor's name/address that will have your medical records including this medical condition?

Thyroid

Was your diagnosis or condition?

1. Hypothyroid?
2. Hyperthyroid?
3. Goiter?
4. Grave's Disease?
5. Hashimoto's?
6. Nodules?
7. Cyst
8. Other

Date of diagnosis for this condition

Treatment (medication)?

If yes, name of medication(s)?

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Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Pituitary

Diagnosis of your condition?

Date of diagnosis of this condition?

Was your diagnosis a?

1. Cyst?
2. Tumor?
3. Unknown?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Adrenal Gland

Was your diagnosis or condition a…

1. Cyst?
2. Tumor?
3. Adrenal Insufficiency?
4. Cushing's Disease?

Date of diagnosis for this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?
Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Endocrine Glands

Diagnosis of your condition?

Date of diagnosis for this condition?

Which gland (pineal, pituitary, pancreas, ovaries, testes, thyroid, parathyroid, hypothalamus, adrenal or unknown)?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Neuromuscular System

Neuromuscular System

Diagnosis of your condition?

Date of diagnosis of this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

Drill Downs

If no, need details

Doctor name/address that will have your medical records, including this medical history

Parkinson's Disease

Date of diagnosis of your condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Muscular Dystrophy

Date of diagnosis of your condition?

Lou Gehrig's Disease

Date of diagnosis of your condition?

Amyotrophic Lateral Sclerosis (ALS)

Date of diagnosis of your condition?

Drill Downs

Drill Downs

Muscles, Joints or Connective Tissues

Muscles

Diagnosis of your condition?

Date of diagnosis of this condition?

Location on body affected?
Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Joints

Diagnosis of your condition?

Date of diagnosis of this condition?

Which joints are affected?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Connective Tissue Disorder

Diagnosis of your condition?

Date of diagnosis of this condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Drill Downs

Rheumatism

Diagnosis of your condition?

Date of diagnosis of this condition?

Location on body affected?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If yes, was it benign (non-cancerous) or malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Arthritis

Joints affected?

- Right Knee?
- Left Knee?
- Right Hip?
- Left Hip?
- Back (Lumbar)?
- Back (Thoracic)?
- Back (Cervical)?
- Back (All)?
- Other?

Date of diagnosis of your condition?

Drill Downs

Was your diagnosis?

- Rheumatoid Arthritis?
- Osteoarthritis?
- Degenerative Arthritis?
- Hypertrophic Arthritis?
- Psoriatic Arthritis?
- Unknown?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Ever had any injections?

If yes, how many?
Date(s) of injections?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Have you ever required the use of any walking aids?

If yes, need date

Type of walking aid?

Date last used?

Doctor name/address that will have your medical records, including this medical history

Drill Downs

Gout

Date of diagnosis of your condition?

How many attacks have you had in the past 12 months?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Fibromyalgia

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Drill Downs

Temporomandibular Joint Disorder (TMJ)

Date of diagnosis of your condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Did your treatment include orthodontic braces?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Lupus

Date of diagnosis of your condition?

Date of last treatment?

Lyme Disease

Date of diagnosis of your condition?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Carpal Tunnel Syndrome

Location of your condition?

- Left wrist?
- Right Wrist?
- Both?

Treatment (medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Do you wear any braces or splints?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor name/address that will have your medical records, including this medical history

Drill Downs

Back, Neck or Spine

Sprain/Strain

Was your final diagnosis Strain/Sprain?

If no, what was your diagnosis?

Date of diagnosis of this condition?

Was an x-ray performed to make a diagnosis?

If yes, what was your diagnosis?

Date of x-ray?

If no, what other type of testing was performed?

Date of other test(s)?

Was there ever a diagnosis of Herniated, Ruptured, Bulging or Slipped Disc made?

Location of this condition?

- Lumbar L1-L4
- Thoracic T1-T12
- Cervical C1-C7
- Scaral/Tailbone S1-S5
- Unknown

Type of treatment?

- Surgery
- Medication
- Physical Therapy
- Spinal Manipulations
- Acupuncture
- Other

Are you still under Treatment for this condition?

If yes, what type of treatment?

If no, date of last treatment?

Type of treatment?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication was last taken?

Have you completely resolved with no further treatment required and no limitations in your daily activities?

If no, need details.

Was any surgery, treatment, or testing recommended and not performed?

If yes, what was recommended?

If no, why was it not performed?

Doctor's name/address that will have medical records including this medical history?

Herniated, Slipped, Bulging or Ruptured Disc

Date of diagnosis of your condition?

Was an x-ray performed to make a diagnosis?

If yes, what was your diagnosis?

Date of x-ray?

If no, what other type of testing was performed?

Date of other test(s)?

Location of your condition?

- Thoracic T1-T12
- Cervical C1-C7
- Sacral/Tailbone S1-S5
- Other

Drill Downs

Type of treatment?

- Surgery
- Medication
- Physical Therapy
- Spinal Manipulations
- Other

Are you still under treatment for this condition?

If yes, what type of treatment?

If no, date of last treatment?

Type of treatment performed?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication was last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was any surgery, treatment, or testing recommended and not performed?

If yes, what was recommended?

If no, why was it not performed?

Have you completely recovered with no further treatment required and no limitations in your daily activity?

If no, what was the date of last pain or symptom?

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Chiropractic Adjustments or Spinal Manipulations

Was the reason for your chiropractic and manipulation visits due to a

- Strain/Sprain
- Herniated, Slipped or Ruptured Disc
- Wellness Maintenance
- Scoliosis

Date of your condition?

Was an x-ray performed to make a diagnosis?

If yes, what was your diagnosis?

Date of x-ray?

If no, what other type of testing was performed?

Date of other test(s)?

Location of your condition?

- Lumbar L1-L4
- Thoracic T1-T12
- Cervical C1-C7
- Sacral/Tailbone S1-S5
- Unknown

Type of treatment?

- Surgery
- Medication
- Physical Therapy
- Spinal Manipulations
- Wellness Maintenance
- Acupuncture

Are you still under treatment for this condition?

If yes, what type of treatment?

If no, date of last treatment?

Treatment (Medication)?

If yes, name of medication(s)?
Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was any surgery, treatment, or testing recommended and not performed?

If yes, what was recommended?

If no, reason it was not performed?

Have you completely recovered with no further treatment required and no limitations in your daily activity?

If no, what was the date of last pain or symptom?

Doctor's name/address that will have your medical records including this medical history?

Wellness Maintenance

Diagnosis of your condition?

- Disc Disorder
- Strain with no Disc Disorder
- Sprain with no Disc Disorder
- No Disc Disorder

Date of diagnosis of this condition?

Was an x-ray performed to make a diagnosis?

If yes, what was your diagnosis?

Date of x-ray?

If no, what other type of testing was performed?

Date of other test(s)?

Drill Downs

Location of your condition?

- Lumbar L1-L4
- Thoracic T1-T12
- Cervical C1-C7
- Sacral/Tailbone S1-S5
- Unknown

Type of treatment?

- Surgery
- Medication
- Physical Therapy
- Spinal Manipulations
- Acupuncture

Are you still under treatment for this condition?

If yes, what type of treatment?

If no, date of last treatment?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication was last taken?

Have you completely recovered with no further treatment required and no limitations in your daily activity?

If no, what was the date of last pain or symptom?

Doctor's name/address that will have your medical records including this medical history?

Scoliosis

Date of diagnosis of your condition?

Was an x-ray performed to make a diagnosis?

If yes, what was your diagnosis?

Drill Downs

Date of x-ray?

If no, what other type of testing was performed?

Date of other test(s)?

Location of your condition?

- Lumbar L1-L4
- Thoracic T1-T12
- Cervical C1-C7
- Sacral/Tailbone S1-S5
- Unknown

Is your condition diagnosed as mild, moderate OR severe, progressive and disabling?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication was last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Do you have any internal fixations such as pins, plates, screws or rods in your back?

If yes, what fixations have been placed?

Date fixations were placed?

Are your fixations permanent?

If no, what date are they to be removed?

Was any surgery, treatment, or testing recommended and not performed?

If yes, what was recommended?

Drill Downs

Do you require the assistance of a walking aid such as cane, walker, wheelchair or any other device?

If yes, which device?

Have you completely recovered with no further treatment required and no limitations in your daily activity?

If no, what was the date of your last pain or symptom?

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Brain or Central Nervous System

Brain or Central Nervous System

Diagnosis of your condition?

Date of diagnosis of this condition?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was a shunt placed?

If yes, is it still in place?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Convulsions

Diagnosis or reason for your condition?

Date of diagnosis for this condition?

Date of last convulsion?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?
Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Date of last convulsion?

Epilepsy

Was your diagnosis a
- Grand Mal
- Petit Mal
- Unknown

Date of diagnosis for this condition?

Date of last seizure?

Treatment (Medication)?

If yes, name of medication(s) and daily dosage?

Do you take your medication every day?

If no, did you discontinue medication on your own?

Did your doctor tell you to stop the medication?

Date medication was last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Drill Downs

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Seizures

Diagnosis or reason for this condition?

Date of diagnosis for this condition?

Date of last seizure?

Type of seizure?

- Grand Mal
- Petit Mal
- Unknown

Treatment (Medication)?

If yes, name of medication(s)?

Do you take your medication every day?

If no, did you discontinue medication on your own?

Did your doctor tell you to stop the medication?

Date medication was last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Recurrent Headaches

What was the cause of this condition?

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication was last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed? Was a MRI or CAT scan done?

If yes, need date?

What were the results?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Migraine(s)

What was the cause of this condition?

Date of diagnosis of this condition?

Date of last migraine?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Drill Downs

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was a MRI or CAT scan done?

If yes, need date?

What were the results?

Was recovery complete with no residuals, impairments or ongoing symptoms?
If no, need details

Doctor's name/address that will have your medical records including this medical history?

Dementia

Date of diagnosis for your condition?

Date of last treatment?

Multiple Sclerosis

Date of diagnosis for your condition?

Date of last treatment?

Paralysis

What was the cause of your paralysis?

Date of diagnosis for this condition?

Areas of body affected?

Treatment (Medication)?

Drill Downs

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Have you or do you require the use of any walking aids?

If yes, what do you use?

Date you required assistance for walking device?

Was recovery complete with no residuals, impairments, or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Skin

Skin

Diagnosis for your condition?

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Psoriasis

Date of diagnosis of your condition?

Was Psoriatic Arthritis diagnosed?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Drill Downs

Is this condition chronic, requiring long term treatment?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will your medical records including this medical history?

Eczema

Date of diagnosis for your condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Is this condition recurrent, severe or disabling?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Eyes, Ears, Nose or Throat

Eyes

Diagnosis of your condition?

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Ears

Diagnosis of your condition?

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Drill Downs

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctors name/address that will have your medical records including this medical history?

Nose

Diagnosis of your condition?

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Throat

Diagnosis of your condition?

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Glaucoma

Date of diagnosis of your condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If no, has surgery been recommended?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will your medical records including this medical history?

Cataracts

Date of diagnosis of your condition?

Are the cataracts in both eyes?

If no, which eye?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If no, has surgery been recommended?

If no, reason it was not performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will your medical records including this medical history?

Blindness

What was the cause of your condition?

Was your condition due to a disease?

If yes, what is the condition or disease?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If no, has surgery been recommended?

If no, reason it was not performed and date?

Are you totally blind?

If yes, which eye?

Are you partially blind?

If yes, which eye?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will your medical records including this medical history?

Tubes in Ears

Diagnosis for your condition?

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Are the tubes still present?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Deafness/Hearing Loss

What was the cause of the deafness?

Date of diagnosis for this condition?

Degree of hearing loss?

Do you wear hearing aides?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

If no, has surgery been recommended with a cochlear implant or other device?

If no reason surgery was not performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Cochlear Implants

Diagnosis of your condition?

Date of diagnosis of this condition?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Drill Downs

Doctor's name/address that will have your medical records including this medical history?

Tonsillitis

Date of diagnosis of your condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Male Reproductive System

Breast

Diagnosis of your condition (male only)?

Date of diagnosis of this condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairment or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Prostate

Diagnosis of your condition?

Date of diagnosis for this condition?

What was your last P.S.A (Prostate Specific Antigen) Reading?

Date of reading?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Was prostate enlarged?

If yes, was a biopsy done or recommended?

If yes, what were the results?

Date of results?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Male Reproductive System

Diagnosis of your condition?

Date of diagnosis for your condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Abnormal P.S.A.

Diagnosis of your condition?

Date of diagnosis for this condition?

What was your last P.S.A. (Prostate Specific Antigen) reading?

Date of reading?

Treatment (Medication)?

If yes, name of medications?
Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was a biopsy performed?

Date of biopsy?

Were the results benign (non-cancerous) or malignant (cancer)?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Impotence

Diagnosis of your condition?

Date of diagnosis of this condition?

Treatment (Medication)?

If yes, name of medications?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Female Reproductive System

Breast

Diagnosis for your condition?

Date of diagnosis for this condition?

Date of last mammogram?

Results of last mammogram?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Was a biopsy performed?

Were the results Benign (Non-Cancerous), Malignant (Cancerous) or Inconclusive?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Female Reproductive System

Diagnosis of your condition?

Date of diagnosis of this condition?

Date of last pap smear?

Was your last pap smear normal?

If no, what was the abnormality?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Endometriosis

Date of diagnosis of your condition?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Type of surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Cyst

Location of cyst?

Date of diagnosis?

Has the cyst been removed, or has a biopsy been performed?

Was the cyst Benign (non-cancerous) or Malignant (cancer)?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

C-Section, Miscarriage, Abortion, or Premature Delivery

Cesarean Section

Date of Cesarean Section?

How many have you had?

Miscarriage

Date of Miscarriage?

Reason or condition for the miscarriage(s)?

How many have you had?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Abortion

Date of Abortion(s)?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Premature delivery

Date of Premature Delivery?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

If child is on the application ask the following questions

How many additional days was the child hospitalized?

Drill Downs

How many weeks premature was the infant?

Was the newborn in NICU?

If yes, How many days?

What was the diagnosis or condition that the child required additional hospitalization?

Any medical or developmental problems with the child?

If yes, what are the developmental problems?

Name and address of the doctor that will have the child's medical records

Newborn

Date of initial newborn check-up?

Results of check-up?

Any abnormal findings?

If yes, what are the findings?

Name, address & tel # of physician with these records?

Date of second newborn check-up?

Results of check-up?

Any abnormal findings?

If yes, what are the findings?

Name, address & tel # of physician with these records?

Have they been advised to consult another physician?

If yes, why?

Drill Downs

Date to be seen?

Name, address & tel # of physician?

Was newborn born prematurely?

If yes, complete---(or just add Premature Delivery DD)

How many additional days was the child hospitalized?

How many weeks premature was the infant?

Was the newborn in NICU?

If yes, How many days?

What was the diagnosis or condition that the child required additional hospitalization?

Any medical or developmental problems with the child?

If yes, what are the developmental problems?

Name and address of the doctor that will have the child's medical records?

Infertility, In-Vitro Fertilization, or Artificial Insemination

Infertility

Date of diagnosis?

Reason or condition for your infertility?

Type of treatment and/or type of procedure?

Was birth given as a result of infertility treatment?

Has birth been given since treatment without fertility treatment?

If yes, what was the date of birth of the child?

Drill Downs

Do you plan or are you contemplating infertility treatments in the future?

If yes, need details

Impotence

Date of diagnosis?

Type of treatment and/or type of procedure?

Was birth given?

Do you plan or are you contemplating any future treatment or procedure?

In-vitro fertilization

Date of diagnosis?

Type of treatment and/or type of procedure?

Was birth given?

Do you plan or are you contemplating any future treatment or procedure?

Artificial insemination

Date of diagnosis?

Type of treatment and/or type of procedure?

Was birth given?

Do you plan or are you contemplating any future treatment or procedure?

Surrogacy

Date of diagnosis of your condition?

Type of treatment and/or type of procedure?

Was birth given?

Sexually Transmitted Disease, Hormone Imbalance, or Oral Contraceptive Reaction

Sexually Transmitted Disease

Date of diagnosis of this condition?

Type of STD?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Hormone imbalance

Date of diagnosis of this condition?

What caused your hormone imbalance?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Surgery?

If yes, date of surgery?

Was surgery performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Oral contraceptive reaction

Date of diagnosis of this condition?

What was the reaction?

How was the reaction treated?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

HIV, AIDS, or AIDS Related Complex

Tested for HIV, AIDS or ARC

Were the results positive or negative?

If positive, need details

How many times have you been tested?

What are the date(s) you were tested?

What is the reason you were tested?

Are you taking any medications for treatment or prevention of HIV?

If yes, what are the name(s) of the medication(s)?

What is the Doctor's name and address with your records?

Cosmetic or Reconstructive Surgery, Congenital Birth Defects, Bodily Deformity, or Organ Transplant

Cosmetic or reconstructive surgery

Surgery?

If yes, date of surgery?

Was surgery performed?

Was your surgery due to a weight loss procedure such as a Gastric Bypass, Sleeve or any other type of procedure?

If yes, what type of procedure?

What was your weight before the surgery?

What is your current weight?

Due to your weight loss surgery, do you have any other complications such as anemia?

If yes, need details

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor’s name/address that will have your medical records including this medical history?

Congenital birth defects

What is the name of the birth defect?

Drill Downs

Monitoring device

Type of monitoring device?

Reason / Diagnosis?

Date?

What part of the body was affected?

If due to a DWI/DUI ask the following questions?

Do you presently use alcohol beverages?

If no, approximate date of last drink?

If yes, date of last drink?

Do you drink Beer, Wine, Liquor or all 3?

How many drinks do you drink daily?

How many drinks do you drink weekly?

How many drinks do you drink monthly?

Have you changed your drinking habits?

If yes, date and reason?

Did you ever drink substantially more than at the present?

If yes, when (from what date-to what date)?

Did you drink Beer, Wine, Liquor or all 3?

How many drinks do you drink daily?

How many drinks do you drink weekly?

How many drinks do you drink monthly?

Drill Downs

Are you active an AA or other recovery groups?

If yes, was it court ordered?

Because of your alcohol use, have you ever consulted a doctor or received treatment?

If yes, need date

Physician / Hospital / address and phone number

Have you ever been arrested for Driving Under the Influence of alcohol?

If yes, date of occurrence?

Driver's license number / County / State?

Briefly describe the event of your occurrence

Have you ever had any of the following?

- Blackouts?
- Convulsions?
- Delirium Tremens?
- Liver Disorder?
- Esophageal Varices?
- Depression or Emotional Disorder?

Implants

What type of implants do you have?

Date of implants?

Reason or diagnosis for your implants?

What part of your body was affected?

Doctor's name / address that will have your medical records including this medical history?

Amputations

Reason / Cause / Diagnosis?

Date of amputation?

Drill Downs

Part of body affected?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details.

Doctor's name / address that will have your medical records including this medical history?

Prosthetic

If yes, reason/diagnosis?

Date of prosthetic?

If yes, part of body affected?

Has it ever needed to be replaced?

If yes, what date was it replaced?

How often does it need to be replaced?

Doctor's name/address that will have your medical records including this medical history

Internal fixations

If yes, date reason/diagnosis?

If yes, date of surgery?

What type of fixations do you have?

Are your fixations temporary or permanent?

If temporary, do you plan to have them removed?

If yes, when?

If yes, part of body affected?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Walking aid

If yes, reason/diagnosis?

What was the date you received a walking aid?

What type of walking aid are you using?

If yes, part of body affected?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Wheelchair

If yes, reason/diagnosis?

Date you received a wheelchair?

If yes, part of body affected?

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Leukemia, Hodgkin's Disease, Lymphoma, or Cancer

Leukemia

Date of diagnosis for this condition

Treatment (Medication)?

If yes, name of medication(s)

Date medication was last taken

Surgery?

If yes, date of surgery

Type of surgery performed

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history

Hodgkin's disease

Date of diagnosis for this condition?

Is your condition diagnosed as Non-Hodgkin's Disease?

Treatment (Medication)?

If yes, name of medication(s)

Date medication was last taken

Surgery?

If yes, date of surgery

Type of surgery performed

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history

Lymphoma

Date of diagnosis for this condition

Treatment (Medication)?

If yes, name of medication(s)

Date medication was last taken

Surgery?

If yes, date of surgery

Type of surgery performed

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history

Cancer

Type of Cancer?

If skin cancer, was your diagnosis?

- Basal Cell
- Squamous Cell
- Melanoma

How many occurrences have you had?

Date of each occurrence?

Drill Downs

Location of Cancer?

Date of Diagnosis?

Treatment (Medication)?

If yes, name of medication(s)

Date medication was last taken

Surgery?

If yes, date of surgery

Type of surgery performed

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history

Drill Downs

Tumor, Cyst, or Any form of growth

Tumor

Location of tumor?

Was the tumor Benign (non-cancerous) or Malignant (cancer)?

Date of diagnosis?

Treatment (Medication)?

If yes, name of medication(s)

Date medication was last taken

Surgery?

If yes, date of surgery

Type of surgery performed

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history

Cyst

Location of cyst?

Date of diagnosis?

Has the cyst been removed, or has a biopsy been performed?

Was the cyst Benign (non-cancerous) or Malignant (cancer)?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Drill Downs

Doctor's name and address that will have your medical records including this medical history

Any form of growth

Date of Diagnosis?

Where is / was the growth located?

Has the growth been removed?

Was a biopsy performed?

Was the growth Benign (non-cancerous) of Malignant (cancer)?

Was recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details.

Doctor's name / address that will have your medical records including this medical history

Drill Downs

Mental/Nervous

Depression

Date of diagnosis?

Is your diagnosis mild depression, moderate depression or major depression?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Have you ever been treated by a Psychiatrist, Psychologist or Counselor?

If yes, which one?

Date of last visit?

How often are your visits?

Have you ever been hospitalized for psychological, nervous, or emotional tests and/or therapy?

If yes, length of hospital stay?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that prescribed your medication?

Have you ever been told you have or received treatment for

- Schizophrenia
- Bipolar Disorder
- Neurosis- Psychoneurosis
- Personality Impairment
- Psychotic Impairment
- Panic Attacks
- Suicidal Ideation
- Obsessive Compulsive Disorder

- Excessive Alcohol or Drug Use

Anxiety

Date of diagnosis?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Have you ever been told you have or received treatment for

- Schizophrenia
- Bipolar Disorder
- Neurosis- Psychoneurosis
- Personality Impairment
- Psychotic Impairment
- Panic Attacks
- Suicidal Ideation
- Obsessive Compulsive Disorder
- Post-Traumatic Stress Disorder
- Anxiety
- Excessive Alcohol or Drug Use

Have you ever been treated by a Psychiatrist, Psychologist or Counselor?

If yes, which one?

Date of last visit?

How often are your visits?

Have you ever been hospitalized for psychological, nervous, or emotional tests and/or therapy?

If yes, length of hospital stay?

Doctor's name and address that prescribed your medication?

Drill Downs

Bulimia

Date of diagnosis?

Have you had surgery, been hospitalized, or been advised to have surgery, therapy, testing or any other treatment?

If yes, need details

Treatment (Medication)?

If yes, name of medication?

Date medication last taken?

What is your current height and weight?

Are you presently being treated or receiving counseling for this condition?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Anorexia

When were you first treated or diagnosed for this condition?

Are you presently being treated or receiving counseling for this condition?

What is your current height and weight?

Treatment (Medication)?

If yes, name of medication?

Date medication last taken?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Bipolar Disorder

Date of diagnosis for this condition?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Have you ever been treated by a Psychiatrist, Psychologist or Counselor?

If yes, date of last visit?

How often are your visits?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name/address that will have your medical records including this medical history?

Mental Retardation

Date of diagnosis?

Treatment (Medication)?
If yes, name of medication(s)?

Date medication last taken?

Have you ever been hospitalized or advised to have therapy, testing or any other treatment?

If yes, need details

Are you presently being treated or receiving counseling for this condition?

What is your current IQ?

Doctor's name/address that will have your medical records including this medical history?

Drill Downs

Learning Disorder

Date of diagnosis?

What is your learning disorder?

Have you received counseling for your learning disorder?

If yes, date of last visit?

Treatment (Medication)?

If yes, name of medication?

Date medication last taken?

Doctor's name/address that will have your medical records including this medical history?

Behavior Disorder

Date of diagnosis of this condition?

Diagnosis of your condition?

Treatment (Medication)?

If yes, name of medication?

Date medication last taken?

Have you received counseling for your behavior disorder?

If yes, date of last visit?

Doctor's name/address that will have your medical records including this medical history?

Attention Deficit Disorder

Date of diagnosis for this condition?

Have you ever been hospitalized or advised to have therapy, testing or any other treatment?

Treatment (Medication)?

If yes, name of medication?

Date medication last taken?

Doctor's name and address that will have your medical history and records including this medical history?

Post -Traumatic Stress Disorder

Date of diagnosis for this condition?

What was the cause of your condition?

Treatment (Medication)?

If yes, name of medication(s)?

Date medication last taken?

Have you ever been treated by a Psychiatrist, Psychologist or Counselor?

If yes, which one?

Date of last visit?

How often are your visits?

Have you ever been hospitalized or advised to have therapy, testing or any other treatment?

If yes, what dates?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history?

Drill Downs

Alcohol or Drug

Advised or treated for alcohol abuse

Date of treatment?

Driver's license number / County / State?

Do you presently use alcohol beverages?

If no, approximate date of last drink?

If yes, date of last drink?

Do you drink Beer, Wine, Liquor or all 3?

How many drinks do you drink daily?

How many drinks do you drink weekly?

How many drinks do you drink monthly?

Have you changed your drinking habits?

If yes, date and reason?

Did you ever drink substantially more than at the present?

If yes, when (from what date-to what date)?

Did you drink Beer, Wine, Liquor or all 3?

How many drinks do you drink daily?

How many drinks do you drink weekly?

How many drinks do you drink monthly?

Are you active an AA or other recovery groups?

If yes, was it court ordered?

Drill Downs

Because of your alcohol use, have you ever consulted a doctor or received treatment?

If yes, need date

Physician / Hospital / address and phone number

Have you ever been arrested for Driving Under the Influence of alcohol?

If yes, date of occurrence?

Driver's license number / County / State?

Briefly describe the event of your occurrence

Have you ever had any of the following?

- Blackouts?
- Convulsions?
- Delirium Tremens?
- Liver Disorder?
- Esophageal Varices?
- Depression or Emotional Disorder?

Advised or treated for drug abuse

Have you used Barbiturates, Sedative or Tranquilizers habitually?

If yes, name of medication(s)?

Date medication last taken?

Have you used LSD, Marijuana, or any amphetamines?

If yes, which drug?

Date last taken?

What period of time did you use?

Have you used cocaine?

If yes, date last taken?

What period of time did you use?

Drill Downs

Have you used heroin, morphine, or other narcotic drug?

If yes, date last taken?

What period of time did you use?

Name and address of doctor or treatment facility that will have your records of treatment

Used illegal drugs

Have you used Barbiturates, Sedative or Tranquilizers habitually?

If yes, name of medication(s)?

Date medication last taken?

Have you used LSD, Marijuana, or any amphetamines?

If yes, which drug?

Date last taken?

What period of time did you use?

Have you used cocaine?

If yes, date last taken?

What period of time did you use?

Have you used heroin, morphine, or other narcotic drug?

If yes, date last taken?

What period of time did you use?

Name and address of doctor or treatment facility that will have your records of treatment

Drill Downs

DUI, DWI, Suspended/Revoked Driver's License, or Felony

Cited for DUI, DWI

How many occurrences have you had?

Date of each occurrence?

Are you currently on probation?

If no, date completed probation?

Driver's license number / County / State?

Do you presently use alcohol beverages?

If no, approximate date of last drink?

If yes, date of last drink?

Do you drink Beer, Wine, Liquor or all 3?

How many drinks do you drink daily?

How many drinks do you drink weekly?

How many drinks do you drink monthly?

Have you changed your drinking habits?

If yes, date and reason?

Did you ever drink substantially more than at the present?

If yes, when (from what date-to what date)?

Did you drink Beer, Wine, Liquor or all 3?

How many drinks do you drink daily?

How many drinks do you drink weekly?

Drill Downs

How many drinks do you drink monthly?

Are you active an AA or other recovery groups?

If yes, was it court ordered?

Because of your alcohol use, have you ever consulted a doctor or received treatment?

If yes, need date

Physician / Hospital / address and phone number

Have you ever been arrested for Driving Under the Influence of alcohol?

If yes, date of occurrence?

Driver's license number / County / State?

Briefly describe the event of your occurrence

Have you ever had any of the following?

- Blackouts?
- Convulsions?
- Delirium Tremens?
- Liver Disorder?
- Esophageal Varices?
- Depression or Emotional Disorder?

Driver's license suspended or revoked in the past 5 years

If yes, what was the offense or reason?

Date of offense?

City and State where the offense occurred?

Driver's license number and state issued?

Has your license been reinstated?

If no, why not?

Drill Downs

Currently on probation

Type of offense?

Date of probation?

City and State where offense occurred?

Driver's license number and state issued?

Convicted of a felony in the past 10 years

What type of criminal activity were you charged with?

Date of activity?

Date of conviction?

Is this your only offense?

If no, what other type of activity or offense?

Date of activity?

Date of conviction?
Was prison time served?

If yes, what years were you incarcerated?

Date of parole/release?

Did you receive probation or court supervision?

If yes, what date?

What is your current occupation and duties?

Name of company?

If owner, how long have you owned?

Drill Downs

Not U.S. Citizen or Permanent Resident

How long have they lived in the U.S.?

What is their occupation? If owner, how long have they owned their own business?

Where were they born?

How often do they travel outside the U.S.?

Where do they travel?

Reason for travel?

What type of Visa do they have?

How often does it need to be renewed?

When did they last renew their Visa?

When does it expire?

What is their social security number?

Are they married and/or have children?

If yes, where do the spouse and children live?

Are they U.S. citizens?

What is spouse's occupation?

Are children in U.S. schools?

Does the insured plan to continue to live in the U.S.?

Or do they plan to move back to homeland?

If moving back, when?

Have they applied for Green Card or U.S. Citizenship?

If yes, When did they apply?

If not, why?

Name, address & telephone number of physician with their records?

Date and reason last seen?

Who is their current insurance carrier?

When did this coverage become effective?

Why are they replacing?

Traveled outside the U.S. for more than 30 days

Where did you travel outside the U.S.? Name of countries visited.

How long and/ or frequent are your trips? Length of stay anticipated?

Purpose of trip? If for business, what type of business?

Drill Downs

Hazardous Avocation or Sports

Race Car Driver

What type of automobile do you race?

What size engine?

Type and size of track?

Maximum speed?

How often do you participate?

Are you considered amateur or professional?

Are you a member of any racing associations?

Have you ever had a wreck?

If yes, have you sustained any injuries?

If yes, what were your injuries? (complete corresponding drill down)

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Sky diving

How often do you sky dive?

Are you a member of a club?

When was the last time you sky dived?

Drill Downs

Pilot

Type of pilot?

Type of aircraft?

Ratings?

Total hours you fly each year?

Total hours as a pilot?

Do you fly professionally?

Do you ever do crop dusting or experimental flying of aircraft?

Are you a student pilot, test pilot, instructor or stunt pilot?

Scuba diving

What type of equipment do you use?

- Skin?
- Scuba?
- Submersible?

What are the locations of your diving activities?

- Cave?
- Under Ice?
- Inland Waters?

How often do you scuba dive?

How many times per week?

How many times per month?

Up to what depth do you submerge?

What is the average time underwater per dive?

Are you currently certified by one of the national training and certification organizations?

Drill Downs

Are you a member of an organized club?

Do you ever dive alone?

Why do you dive?
- Recreation?
- Occupational?

Do you now dive for or contemplate diving for compensation?

Do you participate in any search and rescue?

Rock or mountain climbing

How long have you been rock climbing?

How many times per year do you climb?

Do you climb indoors or outdoors?
- Indoors?
- Outdoors?

How many feet up do you climb?

What kind of climbing do you do? Traditional, Sport, Lead, or Other?
- Traditional?
- Sport?
- Lead?

Any caves?

How many people do you climb with in a group?

Where do you climb?

Do you travel outside the United States?

Any search and rescue?

Drill Downs

Rodeo

What events do you participate?

How often?

When was the last time you participated?

Do you rodeo full-time?

If no, do you have another job?

If yes, what are your occupation and duties?

Have you ever been injured?

Bail Bondsman

Do you own the company?

Name of company?

How many hours do you work in office?

When bail is violated, do you ever go after / apprehend client?

Do you apprehend alone, with a partner or team?

Do you carry a gun?

Bartender

Name and location (city/state) of establishment where you bartend?

What is the % of alcohol served vs. % of food served?

- Night Club/Dance Club?
- Gentleman's Club?
- Bar/Lounge?

- Casino?
- Restaurant with a Bar Area?

What are your occupational duties at this establishment?

- Owner?
- Manager?
- Host?
- Bartender?
- Book Keeper?
- Other?

How many hours per week do you work at this establishment?

If part-time only, what is your other occupation?

How many hours a week do you work as a bartender?
How long have you been bartending?

What was your prior occupation?

Do you presently use alcohol beverages?

Have you changed your drinking habits?

Did you ever drink substantially more than at the present?

Are you active in AA or other recovery groups?

Because of your alcohol use, have you ever consulted a doctor or received treatment?

Have you ever been arrested for Driving Under the Influence of alcohol?

Boating & Fishing

What is your occupational position and duties?

How many miles do you travel from shore?

How long do you stay out each time?

Do you come ashore every night?

How large is the crew?

What is the length of the boat?

Bridge Inspector

Up to what height do you climb?

Do you work under water?

What type of equipment is used?

What type of safety gear is used?

Do you work with explosives?

Do you travel outside the United States?

Chimney Sweep

What is the name and address of the company?

Are any chemicals used considered hazardous?

What is your position and duties? (If owner, how many employees do you have?

How many hours per week do you work in the office?

How many hours per week do you perform chimney sweep duties?

Up to how many stories do you work?

Do you wear protective clothes and respirators?

Do you use any of the following: Safety Belt, Harness, Pulley System or Other?

- Safety?
- Harness?
- Pulley System?
- Other?

Have you ever experienced any medical conditions related to your occupation?

Drill Downs

If they no longer perform chimney sweep duties, please ask the following: At any time during the year, have you ever been pressed to chimney sweep?

Flooring

How many hours per week do you install floors or floor covering?

What type of flooring do you install (wood, carpet or tile)?

How many hours a week do you spend in the office?

How long have you been installing floors or floor covering?

Have you had injuries and/or disabilities as a result of installing floors or floor covering?

If yes, what were your injuries (text) (complete corresponding drill down)

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Forest Industry

What is your position? If an Owner, How many employees do you have?

What are your duties?

What machines do you use?

How many hours per week do you spend in the office?

Do you work in the field?

Do you climb?

Do you drive?

Do you work alone or in a group?

Drill Downs

Horse Trainer Instructor

What is your position?

What are your duties as an instructor and care taker of horses?

Do you teach horses, people on horses or both?

What disciplines do you teach?

Have you had any injuries or disabilities from horse training?

If yes, what were your injuries (complete corresponding drill down)?

How many hours per week do you work in the office?

How many hours per week do you instruct?

Do you have employees?

Do you compete in any competitions?

Ice Climbing

How long have you been ice climbing?

How many times a year do you climb?

How many feet up do you climb?

What slopes do you climb?

- Flat Ice?
- Short/Low Angled?
- Long and Steep?
- Waterfalls?
- Other?

What ice tools do you use?

- Crampons?
- Ice Axe?
- Ice Screws?

How many people do you climb with in a group?

Drill Downs

Where do you climb?

Do you travel outside the United States?

Any search and rescue?

Logger Drill

What is your position? If an owner, How many employees do you have?

What are your duties?

What machines do you use?

How many hours per week are spent in the office?

Do you work in the field?

Martial Arts

Do you compete in competitions?

If yes, how many times per year?

If no, when was the last time?

Have you sustained any injuries due to martial arts training, instructing or competition?

If yes, what were the injuries?

Date of injury?

How were the injuries treated?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details?

Drill Downs

Motorcross

Do you race professionally?

Who is your sponsor?

What is the size of your motorcycle?

How often do you race?

Are you a member of any professional organization related to racing?

Do you have any other job providing income other than racing?

Have you ever been injured while racing?

What type of racing do you do? (Motocross, cross country etc.)?

Musician/Entertainer

Where do you perform?

- Night Clubs?
- Festivals?
- Church?
- Theater?

What kind of music do you play?

Name of band?

How often do they play and time of day?

Do you perform in places that sale alcohol?

If yes, (complete alcohol drill down)

Oil Field

What is your position?

What are your duties?

Drill Downs

Do you work in the field?

If yes, how many hours per week?

How many hours a week do you work in the office?

Where do you work? (out of the country, in the United States, etc.)

Have you ever worked on an offshore rig?

Painter

What do you paint?

- Bridges?
- Houses?
- Commercial Buildings?

How many stories/feet up do you paint?

Do you use any of the following:

- Safety Belt?
- Harness?
- Pulley System?
- Other?

Do you wear a respirator while painting?

Any sandblasting?

If yes, what do you sandblast?

How often do you sandblast?

Private Investigator

Do you carry a gun?

What type of investigating do you do?

What city and state do you work?

Drill Downs

What is your position and/or title?

How many hours per week do you work in the office?

How many hours per week do you work in the field?

Do you work alone or with a partner?
- Alone?
- With Partner?

Do you have employees?

Roofer/Estimator

What is your position?

What are your duties?

How many hours per week are spent in the office?

How many hours per week are spent roofing?

Commercial or residential?
- Commercial?
- Residential?

Up to how many stories do you work?

Do you use any of the following: Safety Belt, Harness, Pulley System or Other?
- Safety Belt?
- Harness?
- Pulley System?
- Other?

If they no longer work in the field please ask the following: At any time during the year are you pressed to roof?

If no longer roofing, do you ever get on a roof to do estimates?

If yes, how many hours per week?

IF ESTIMATOR ONLY, how does he get the measurements in order to estimate (drone, google maps, etc..)?

Drill Downs

Sandblasting

What do you sandblast?

How many stories/feet up do you work?

Do you use any of the following: Safety Belt, Harness, Pulley System or Other?

- Safety Belt?
- Harness?
- Pulley System?
- Other?

Do you wear a forced air full face helmet?

Do you wear a respirator?

Ever had any abnormal chest x-rays or other tests?

Snow Avocation

In what snow sport do you participate?

- Skiing?
- Backwoods Skiing?
- Backwoods Boarding?
- Shoeing?
- Other?

Are you a Professional, Company Owner, Instructor or Amateur?

Any participation in ski patrol or search and rescue?

Arborist and Tree Trimmer

What is your position?

Drill Downs

What are your duties?

How many hours per week are spent in the office?

How many hours per week do you trim trees?

How high do you climb (in feet)?

If they no longer trim trees, please ask the following: When was the last time you trimmed a tree? (need a date)

If they no longer trim trees, please ask the following: At any time during the year are you ever pressed to trim trees?

Tile Worker

What company do you work for?

What is your occupation?

What are your duties?

In what locations do you install tile (floors, showers, back splash, walls, etc..)?

How many hours per week do you spend in the office?

How many hours do you install tile floors?

How long have you been installing tile?

Have you had any injuries and/or disabilities as a result of installing tile floors?

if yes, what were your injuries (complete corresponding drill down)

is recovery complete with no residuals, impairments or ongoing symptoms?

if no, need details.

Window Washer

What is your position?

What are your duties?

Drill Downs

How many hours per week are spent in the office?

How many hours per week are spent cleaning windows?

Do you wash commercial buildings or residential buildings?

- Commercial Buildings?
- Residential Buildings?

How many stories up do you work?

Do you use any safety equipment such as a Safety Belt, Harness, Pulley System, etc?

If they no longer Clean windows, please ask the following: At any time during the year, have you been pressed to clean windows?

Mining

How many hours per week do you spend working inside the mine?

If none, please describe your occupational duties?

Fireman

Are you a fireman at a municipal fire department?

Are you a forest fire fighter?

Have you ever been injured performing your duties?

If yes, what were your injuries? (complete corresponding drill down)

Construction

Do you do any demolition work?

If yes, need details of occupational duties?

Do you construct high rise tower?

If yes, need details of occupational duties?

Have you ever been injured on the job?

If yes, what were your injuries? (complete corresponding drill down)

Lineman

How high up do you work performing your duties as a lineman?

Do you climb or use a cherry picker?

Have you ever been injured performing your occupational duties?

If yes, what were your injuries? (complete corresponding drill down)

Iron Worker

Do you work on high rise structural steel construction?

If no, provide details of your job?

How high up do you typically work?

Have you ever been injured performing your occupational duties?

If yes, what were your injuries? (complete corresponding drill down)

Hazardous Waste Handler

What type of waste do you work with?

Drill Downs

Active Military

What branch do you serve (army, navy, marines, air force, national guard or reserves)?

Tattoo Artist

How long have you been a tattoo artist?

Name and address of establishment?

What was your prior occupation?

Actors/Actress/Entertainer/Performer

What type of acting, performing or entertaining do you do?

How long have you been performing?

Do you travel?

If yes, where?

Do you perform in places that sell alcohol?

If yes, complete alcohol drill down

Medicaid, Medicare, Social Security, Disability, or Workers Compensation

Medicaid

Was the reason you applied or received Medicaid due to financial assistance?
Was the reason due to a medical condition, illness or injury?
If yes, what was the condition or diagnosis? (complete corresponding drill down for condition)
Date coverage began?
Date coverage ended, if no longer receiving?

Medicare

What was the reason you applied or received Medicare?
Was the reason due to a medical condition, illness or injury?
If yes, what was the condition or diagnosis? (complete corresponding drill down for condition)
Date coverage began?

Date coverage ended, if no longer receiving

Social Security

What was the reason you applied or received Social Security?

Was the reason due to a medical condition, illness or injury?
If yes, what was the condition or diagnosis? (complete corresponding drill down for condition)
Date coverage began?

Date coverage ended, if no longer receiving

Disability

What was the reason you applied or received Disability?

Are you currently disabled?

If yes, what was the condition or diagnosis? (complete corresponding drill down for condition)
Date coverage began?

Date coverage ended, if no longer receiving

Workers Compensation

What was the condition or diagnosis that you received Worker's Compensation? (complete corresponding drill down for condition)

Date coverage began

Are you currently receiving Worker's Compensation?
If no, what was the date you were fully released from medical care?
Are you fully recovered with no residuals, impairments or ongoing symptoms?
If no, need details

Prescription Drug History & Authorization

Prescription Drug History

Name of Medication?

Dosage?

Are you still taking this medication?

If "No," date you stopped and reason you stopped taking this prescription?

What was the exact diagnosis that the Doctor made regarding this prescription?

Were you ever hospitalized for this diagnosis/condition?

If "Yes," we need the date and reason.

Was any surgery discussed, recommended, or done?

If "Yes," give details.

Are any symptoms, pain, or limitations still present?

Drill Downs

If "Yes," give details

Name and Address of the Doctor who prescribed this medication.

Prescription Authorization

Rx Auth verbiage from script:

> So, we can proceed, I need to ask you to authorize any licensed physician, medical facility, pharmacy, pharmacy benefit manager, MIB who possesses any health and prescription information for any of the individuals listed on the application, to furnish such information to [Freedom Life Insurance Company of America / National Foundation Life] if needed for the purpose of evaluating the application for insurance. *This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.* If health information is obtained it will not be disclosed without authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization will be valid for two years from this date and may be revoked by sending written notice to [Freedom Life Insurance Company of America / National Foundation Life]. Can I have your authorization for this? *("Yes" response needed)*.

Bank Authorization

We need bank auth from (NAME) call (TEL #). Also verify name on the account, address, phone number routing and account number.

Generalized Ailment Drill Down

Was a final diagnosis given regarding your condition?

If yes, what was the diagnosis of your condition?

Date of diagnosis for this condition?

Have you taken any Treatment (Medication)?

Drill Downs

If yes, name of medication(s)

Was there any Surgery performed?

Date of Surgery?

What type of surgery was performed?

Was any surgery, treatment or testing recommended and not performed?

What was recommended?

Why was it not performed?

Is recovery complete with no residuals, impairments or ongoing symptoms?

If no, need details

Doctor's name and address that will have your medical records including this medical history?