Personal Health Questionnaire (PHQ)

Employee Name: ______________________ **Employer Name:** ______________________

Daytime Phone: (   )   - ______________ **Date of Hire:** ______________________

Are you planning to enroll in your employer's health insurance plan? ☐ **Yes** ☐ **No**

***** If you selected "No", please select one of the following, then skip the remainder of the form and sign the bottom of p. 2.**

☐ **Covered by Spouse's plan** ☐ **Not Eligible**

☐ **Do Not Want Coverage** ☐ **Other Reason (______________________________)**

· ***If you selected "yes," please complete the rest of this form.***
· *Answer the following questions for yourself and eligible enrolling family members.*
· *Include additional sheets for detailed explanations or additional dependents.*
· *All questions must be answered or the form may not be accepted.*

I. Demographic, Build and Tobacco Use

	Relation to Employee	Member Name	Gender (M / F)	Date of Birth (mm/dd/yyyy)	Height		Weight (lbs)	Home Zip Code	Tobacco use in last year? (Yes / No)
					ft.	in.			
1	Employee								
2	Spouse								
3	Child								
4	Child								
5	Child								
6	Child								

II. Medical Conditions & Treatments

Has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hosptialized for any of the following?

***** Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on p. 2 for ALL "Yes" answers.**

1. Cancer (if yes, list location and type of cancer below) **Yes** ☐ **No** ☐

Location and type of cancer ___________________

Check one: ___Stage 1, ___Stage 2, ___Stage 3, ___higher

Date of remission (if applicable):

2. Cardiac or Heart Disease / Disorder **Yes** ☐ **No** ☐

If yes, check all that apply:

___ heart attack,
___ bypass surgery or angioplasty on **single** vessel, or
___ bypass surgery or angioplasty on **multiple** vessels;
___ **ANY other heart conditions (list here):** ______________________
(i.e. arrhythmia, aneurysm, heart failure, heart valve disorder)

3. Diabetes (if yes, list type 1 or 2) **Yes** ☐ **No** ☐

Type: ________________________________

If yes, list 3 most recent HbA1c / fasting blood sugar levels:

1) 2) 3)

4. High Cholesterol **Yes** ☐ **No** ☐

If yes, list 3 most recent readings:

1) 2) 3)

5. High Blood Pressure **Yes** ☐ **No** ☐

If yes, list 3 most recent readings:

1) 2) 3)

	Yes	No
6. Arthritis (i.e. rheumatoid, osteo, psoriatic, gout)	☐	☐
7. Autoimmune Disease (i.e. lupus, MS, anemia)	☐	☐
8. Back Disorder (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain)	☐	☐
9. Benign Growth (i.e. tumor, cyst)	☐	☐
10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis)	☐	☐
11. Circulatory System Disease (i.e. stroke, arterial / vascular diseases)	☐	☐
12. Immunodeficiency (i.e. AIDS, HIV+, hemophilia)	☐	☐
13. Kidney Disorder (i.e. nephritis, renal failure)	☐	☐
14. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E)	☐	☐
15. Mental Illness (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia)	☐	☐
16. Counseling Current or prior counseling?	☐	☐
17. Muscular Disorder	☐	☐
18. Respiratory (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis)	☐	☐
19. Stomach (i.e. ulcer, acid reflux, GERD)	☐	☐
20. Substance dependency (i.e. alcohol, drug)	☐	☐
21. Transplants (if yes, list organ(s): _____________)	☐	☐

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II. Medical Conditions & Treatments (continued)

	Yes	No
22. Is anyone currently taking **prescription medication(s)**?		
23. Has anyone had any of the following for a **serious illness** in the past 5 years?		
a) treatment		
b) hospitalization		
c) surgery		
24. Is anyone **currently**:		
a) hospitalized or confined in a treatment facility?		
b) confined at home, incapacitated or incapable of self-support?		
25. Is any of the following **pending**?		
a) treatment (medical treatment or diagnostic testing)		
b) hospitalization		
c) surgery		
26. In the past 5 years, has anyone enrolling had **symptoms** of any serious medical condition not yet indicated on this form?		

Reminder:
Please complete ADDITIONAL DETAIL TABLE for **ALL** items answered "YES" on Pages 1 & 2

III. Pregnancy and Childbirth

	Yes	No
27. Is anyone **pregnant?** (If no, mark "No" and skip question 27.)		
a) The due date is:________________________		
b) Is this a High Risk Pregnancy, any complications or bleeding?		
c) Previous c-section or pre-term birth?		

d) Are multiple births expected? If so, please check one: ___**twins** ___**triplets** ___**more**

ADDITIONAL DETAIL TABLE - Please Fill In Details Below For All Questions Answered "YES"

Question #	Name of Individual	Condition / Diagnosis	Date of Onset	Last Date Treated	Treatment / Drug	Still taking? (Y / N)	Degree of Recovery

*** If you marked "Yes" to any item on Page 1 or 2, please complete ADDITIONAL DETAIL TABLE above, or this form will not be accepted.**

In the event that information has been intentionally omitted or misrepresented, the insurance carrier may deny or limit coverage, furthermore, the Advantage Health Plans Trust service agreement may terminate for breach. In such cases, I understand that Advantage Health Plans Trust or the carrier may change my insurance premiums. I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage.

This information is gathered for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment. In compliance with requirements for GINA, Advantage Health Plans Trust is not requesting genetic information.

My healthcare provider's notice of privacy practices provides more detailed information about how my protected health information is disclosed. I have a legal right to review a notice of privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. The Advantage Health Plans Trust Program and my health plan are not required by law to grant my request. However, if my request is granted, the Advantage Health Plans Trust Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the Advantage Health Plans Trust Program or my health plan have already used or disclosed my protected health information in reliance upon my consent. I will notify Advantage Health Plans Trust of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the health plan.

Employee SIGN HERE and Date:

➡ ____ Date:_____________________