Short Form Health Questionnaire

First Name	Last Name	Age	Height Ft & Inches	Weight	Gender	Any tobacco use in the past 12 months Y or N?

1. Are you, or any dependent to be covered:
   a. Currently pregnant or have reason to suspect you might be pregnant? **Circle YES** or **NO**
   b. Financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption? **Circle YES** or **NO**
2. In the past 24 months, have you, or any dependent to be covered, been recommended to have, or been scheduled for, diagnostic testing, treatment, or surgery that has not been completed? **Circle YES** or **NO**
3. Within the past 24 months, have you, or any dependent to be covered, had a health related condition for which they have not sought medical advice or treatment? **Circle YES** or **NO**
4. Within the past five years, have you, or any other dependent to be covered, received any abnormal test results, medical or surgical treatment, healthcare professional consultation, or prescribed medication for any of the following conditions? **Circle YES** or **NO and circle all that apply**
   a. Arthritis, Reumatologic disorder or any disease or disorder of the joints, bones, muscles or back
   b. AIDS or tested positive for HIV
   c. Asthma, Emphysema, COPD, TB, or any other disease or disorder of the respiratory system
   d. Cardiovascular disease or disorder of the heart , arteries, blood vessels or blood
   e. Cancer or tumor
   f. Chemical dependency, drug or alcohol abuse, or any other mental health disease or disorder
   g. Crohn's disease, ulcerative colitis, hepatitis or any other disorder of the liver, stomach, colon or intestines
   h. Diabetes or any other disorder of the pancreas
   i. Immune system disease or disorder
   j. Kidney disease or disorder
   k. Neurological system disorder
   l. Stroke

If you answered **yes to any of the above questions**, please explain including: Name of person, date of condition, conditions treatments, and medications, expected future treatments and other information to better understand your needs.

Name of person	Date of incident or of last treatment	Explain condition	Explain treatment including any expected future treatment including medications (use back of page if you need more room)

I certify that the above information is true to the best of my knowledge. I understand that this may become part of an application for health insurance and is subject to the Utah code regarding such applications.

Signature____ Date____________________