HTH Global HealthGuard
Health Questionnaire

Member Name: Date of Birth: Group Name:

The following information is confidential and will not be seen or given to your employer.
HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 1-10 EMPLOYEES AND LATE ENROLEES:

HEALTH HISTORY OF YOU AND YOUR FAMILY (Include information on all family members you wish to cover.)

Has any person listed on this application ever had, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions? All questions must be answered **"Yes" or "No."**

INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

		YES	NO
1.	Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipemia, or arteriosclerosis?	☐	☐
2.	Ulcer colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder or liver?	☐	☐
3.	Cancer, tumor or cyst?	☐	☐
4.	Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction?	☐	☐
5.	Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system?	☐	☐
6.	Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ___________	☐	☐
7.	Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones?	☐	☐
8.	Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn and/or congenital problems?	☐	☐
9.	Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing?	☐	
10.	Within the last five years, had an e-ray, electrocardiogram, cardiovascular exam, or any laboratory test or study?	☐	☐
11.	Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner?	☐	☐
12.	Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?	☐	☐
13.	a. Is any female to be covered currently pregnant? If yes, Due Date (month): ___________ b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?	☐	☐
14.	Any history of complication of pregnancy?	☐	☐
15.	Does anyone listed on this application use tobacco products?	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING.

Please explain and provide us with **FULL DETAILS** for each "Yes" answer to any condition(s) checked in all the preceding boxes. In addition, **please give details below of last doctor visit and/or physical examination for ALL family members listed regardless of the date or reason.** (Insert additional sheets if necessary.)

Question #	Name of Family Member (As identified on physician's record)		Question #	Name of Family Member (As identified on physician's record)	
Date of Onset/Treatment (MoYr)	Date Ended	☐ Still under treatment	Date of Onset/Treatment (Mo/Yr)	Date Ended	☐ Still under treatment
Name of Condition(s)/Illness(es) Treated			Name of Condition(s)/Illness(es) Treated		
Treatment Rendered			Treatment Rendered		
Medication (if taken)	Date Prescribed	Dosage	Medication (if any)	Date Prescribed	Dosage
Question #	Name of Family Member (As identified on physician's record)		Question #	Name of Family Member (As identified on physician's record)	
Date of Onset/Treatment (MoYr)	Date Ended	☐ Still under treatment	Date of Onset/Treatment (Mo/Yr)	Date Ended	☐ Still under treatment
Name of Condition(s)/Illness(es) Treated			Name of Condition(s)/Illness(es) Treated		
Treatment Rendered			Treatment Rendered		
Medication (if taken)	Date Prescribed	Dosage	Medication (if any)	Date Prescribed	Dosage

Add additional sheets if necessary.