



# Confidential Employee Health Questionnaire

Complete One Questionnaire for Each Employee

Employees return this form to your company's CHC designee. Return before June 19, 2009

Cooperative Health Choices of Western Wisconsin • Phone: (715) 381-4383

Name of Employer: \_\_\_\_\_ Date: \_\_\_\_\_

County: \_\_\_\_\_ Employee # \_\_\_\_\_  Employee Waives Coverage (if waiving, stop here & return form)

## A. EMPLOYEE AND DEPENDENT INFORMATION – List all family members to be covered

Member Code	Year of Birth	Gender (circle one)	Height	Weight	Full-Time Student?
Employee = EE		M or F	____ft. ____in.	_____pounds	Yes or No
Spouse = SP		M or F	____ft. ____in.	_____pounds	Yes or No
Child 1 = C1		M or F	____ft. ____in.	_____pounds	Yes or No
Child 2 = C2		M or F	____ft. ____in.	_____pounds	Yes or No
Child 3 = C3		M or F	____ft. ____in.	_____pounds	Yes or No
Child 4 = C4		M or F	____ft. ____in.	_____pounds	Yes or No
Child 5 = C5		M or F	____ft. ____in.	_____pounds	Yes or No

## B. HEALTH INFORMATION – Required for all Members applying for coverage, including newborns

Check every yes or no box, and circle the medical condition(s) for all questions answered yes, for you and your family members applying for coverage.

- 1. In the last 5 years, have you or your dependents had or been treated for:** YES NO
- a. Diabetes or sugar, protein, or blood in the urine? Date diagnosed \_\_\_\_\_ A1C reading \_\_\_\_\_
  - b. High blood pressure \_\_\_\_\_ (reading), chest pains, heart murmur, shortness of breath, angina, or other heart, blood or circulatory disorder?
  - c. Stroke, multiple sclerosis, cerebral palsy, seizures, headaches or other disorder of the brain or nervous system?
  - d. Asthma, allergies, (receiving shots? \_\_\_\_\_) emphysema, lung or respiratory disorder?
  - e. Digestive disorder, ulcer, hepatitis\*, or any disorder of gallbladder, liver, stomach or intestines?
  - f. Varicose veins, skin ulcerations, phlebitis, or hernia or any kind?
  - g. Kidney, bladder, prostate or urinary disorder?
  - h. Disorder of breast or reproductive organs (male or female), infertility, or abnormal menstrual period?
  - i. Rheumatoid arthritis, osteo arthritis, TMJ, or any disorder of the joints, muscles, back or bones?
  - j. Cancer, tumor, cyst, or growth of any kind?
  - k. Disorders relating to the immune system including HIV positive\*, AIDS\*, lupus, or any connective tissue disease?
  - l. Any disorder of eyes, ears, nose, or throat?
- 2. Are any persons to be covered pregnant?**    
If yes, list due date, any complications or multiple Births expected \_\_\_\_\_
- 3. In the last 5 years, have you or your dependents:** YES NO
- a. Been treated for alcohol or drug abuse or joined any programs for alcoholism or drug abuse?
  - b. Been seen for psychological disorders, anxiety, eating disorder or had professional counseling?
  - c. Had any medical treatment, health, mental or physical impairment, surgery, or congenital disorder, not mentioned above?
  - d. Had a medical examination, electrocardiogram, x-ray, blood test, or diagnostic test?
- 4. Is anyone:**
- a. Currently receiving disability for worker's compensation or payments from an auto carrier for an injury?    
Final payment received?
  - b. Currently disabled, hospitalized or on a medical leave?
- 5. Is anyone:**
- a. Scheduled for an organ or other type of transplant or implant?
- 6. Has anyone in the last year**
- Used tobacco or smokeless products?    
If yes, how much per day? \_\_\_\_\_  
Date ended \_\_\_\_\_
- 7. Within the last 5 years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not mentioned in this application?**

Explain "YES" answers to any of the above questions with complete details. (Attach additional pages as needed & label with employee number.)

Question Number	Member Code	Diagnosis or details about condition, treatment or medication	Date of Onset	Date of Recovery	# Days in Hospital

Please list all prescribed medications taken in the last year – List the drug plus member code of whom prescription is for:

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