THE OHIO CHAMBER ALLIANCE, INC.
HEALTHCARE QUESTIONNAIRE

Name:	Height:	Weight:

HEALTH HISTORY INFORMATION

1. Have you or your dependents had or been treated during the past ten years for:

	Yes	No
A. diabetes or sugar, albumin or blood in the urine: If yes, when first diagnosed?	☐	☐
B. high blood pressure, chest pain, heart murmur, shortness of breath, angina or other heart or circulatory disorder?	☐	☐
C. stroke, epilepsy, fainting, dizziness, headaches or any disorder of the brain or nervous system?	☐	☐
D. tuberculosis, asthma, hay fever, lung or respiratory disorder?	☐	☐
E. stomach or duodenal ulcer, other ulcer, colitis, disorder of gall bladder, liver, stomach or intestines?	☐	☐
F. varicose veins, varicose ulcers, or phlebitis or hernia of any kind?	☐	☐
G. kidney, bladder or prostate disorder or other urinary disorder?	☐	☐
H. tumor or disease or dysfunction of the breast, reproductive organs or abnormal menstrual period?	☐	☐
I. arthritis, rheumatism or any pain/disorder of the joints, muscles, back or bones?	☐	☐
J. cancer or tumor or ulcer of any kind, growth or cyst?	☐	☐
K. any disorder of the eyes, ears, nose or throat?	☐	☐
L. alcoholism, drug habit (or have your dependents joined any organization for alcoholism or drug abuse)?	☐	☐
M. nervous, mental, or sleep disorder (including professional counseling)?	☐	☐
N. disease of the immune system including AIDS or ARC?	☐	☐

2. Have you or your dependents:

	Yes	No
A. had any life or health insurance declined, postponed or modified, or had a waiver or extra premium added?	☐	☐
B. been released from the military for medical reasons?	☐	☐
C. received payment for disability, illness or injury?	☐	☐
D. had a change of weight of more than 10 pounds in the last 12 months?	☐	☐

3. Within the past 5 years, have you or your dependents:

	Yes	No
A. had a physical examination, electrocardiogram, x-ray, blood test or diagnostic test, or seen a physician for any medical reason?	☐	☐
B. had inpatient or outpatient surgery?	☐	☐
C. been advised to have surgery not yet done?	☐	☐
D. had any medical treatment, mental or physical impairment, condition or congenital anomaly not mentioned above?	☐	☐

4. Have medications been prescribed for your or your dependents in the past 12 months for any reason?

	Yes	No
If yes, please list name, dose, and condition used for:	☐	☐

5. Are any family members pregnant (including spouse not applying for coverage)?

	Yes	No
A. If yes, when is delivery expected? B. If no, date of last menstrual cycle?	☐	☐

Explain "YES" answers to any part of question 1,2,3. Give complete Details. Use extra paper if necessary.

Question No Name	Diagnosis, Treatment or Reason for Physical Checkup