Reset Form

GuideStone® Financial Resources

# Personal Health Questionnaire for Employees in a Small Group

Employee name: _____ Employer name: _____

Daytime telephone: (_____)_____ Email address: _____ 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 page 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 ft. | Height in. | Weight (lbs) | Home ZIP Code | Tobacco Use in Last Year? (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Employee | | | ___/___/___ | | | | | |
| 2 | Spouse | | | ___/___/___ | | | | | |
| 3 | Child | | | ___/___/___ | | | | | |
| 4 | Child | | | ___/___/___ | | | | | |
| 5 | Child | | | ___/___/___ | | | | | |
| 6 | Child | | | ___/___/___ | | | | | |

## II. MEDICAL CONDITIONS AND TREATMENTS

In the past 5 years, has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following?

**Check "Yes" or "No" for each question. Please complete ADDITIONAL DETAIL TABLE on page 2 for ALL "Yes" answers.**

**1. Cancer** (If yes, list location and type of cancer.) ☐ 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
☐ Bypass surgery or angioplasty on **multiple** vessels
☐ **ANY other heart conditions (list here):** _____
(e.g., 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** (e.g., rheumatoid, osteo, psoriatic, gout) | ☐ | ☐ |
| **7. Autoimmune disease** (e.g., lupus, MS, anemia) | ☐ | ☐ |
| **8. Back disorder** (e.g., degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain) | ☐ | ☐ |
| **9. Benign growth** (e.g., tumor, cyst) | ☐ | ☐ |
| **10. Bowel** (e.g., irritable bowel syndrome, Crohn's disease) | ☐ | ☐ |
| **11. Circulatory system disease** (e.g., stroke, arterial/vascular diseases) | ☐ | ☐ |
| **12. Immunodeficiency** (e.g., AIDS, HIV+, hemophilia) | ☐ | ☐ |
| **13. Kidney disorder** (e.g., nephritis, renal failure) | ☐ | ☐ |
| **14. Liver disease** (e.g., cirrhosis, hepatitis A, B, C, E) | ☐ | ☐ |
| **15. Mental illness** (e.g., mild or major depression, anxiety, bipolar disorder, schizophrenia) | ☐ | ☐ |
| **16. Counseling** (current or prior counseling) | ☐ | ☐ |
| **17. Muscular disorder** | ☐ | ☐ |
| **18. Respiratory** (e.g., asthma, allergies, pneumonia, COPD, emphysema, bronchitis) | ☐ | ☐ |
| **19. Stomach** (e.g., ulcer, acid reflux, GERD) | ☐ | ☐ |

Employee name: _____ Employer name: _____

## II. MEDICAL CONDITIONS AND TREATMENTS (CONTINUED)

| | Yes | No |
|---|---|---|
| **20. Substance dependency** (e.g., alcohol, drug) | ☐ | ☐ |
| **21. Transplants** (If yes, list organ(s):_____) | ☐ | ☐ |
| **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.** Does anyone have 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? | ☐ | ☐ |

## III. PREGNANY 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) Has individual experienced previous C-sections or pre-term births? | ☐ | ☐ |
| d) Are there multiple births expected? If so, please check one: | ☐ | ☐ |
| ☐ Twins ☐ Triplets ☐ More | | |

**Reminder: Please complete ADDITIONAL DETAIL TABLE for ALL items answered "Yes" on pages 1 and 2.**

## 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? (Yes/No) | Degree of Recovery |
|---|---|---|---|---|---|---|---|
| | | | ___/___/___ | ___/___/___ | | | |
| | | | ___/___/___ | ___/___/___ | | | |
| | | | ___/___/___ | ___/___/___ | | | |
| | | | ___/___/___ | ___/___/___ | | | |
| | | | ___/___/___ | ___/___/___ | | | |
| | | | ___/___/___ | ___/___/___ | | | |
| | | | ___/___/___ | ___/___/___ | | | |
| | | | ___/___/___ | ___/___/___ | | | |
| | | | ___/___/___ | ___/___/___ | | | |

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

## EMPLOYEE SIGNATURE

I represent that all statements and answers I have given are complete and accurate to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete or misleading information to GuideStone Financial Resources for the purpose of defrauding the medical plan. Penalties may include fines or denial of medical benefits. I will promptly inform GuideStone in writing before my coverage takes effect if I become aware that anything has occurred and makes this health statement incomplete or incorrect. I understand that I or any other adult to be covered by this policy may be contacted for additional information or asked to sign an authorization for the release of medical records. Health care providers listed on this form will not be contacted unless I or my dependent signs a separate written medical authorization.

**Employee signature:** _____ **Date:** _____/_____/_____

 