



| NUMBERING FOR EBLUE MEDICAL QUESTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| <p><b>EVER HAD:</b></p> <p><b>1. DIABETES MELLITUS?</b></p> <p>a. Date initially diagnosed?</p> <ul style="list-style-type: none"> <li>• Less than 1 year ago</li> <li>• 1-2 years ago</li> <li>• 3-5 years ago</li> <li>• Greater than 5 years ago</li> <li>• Juvenile onset</li> </ul> <p>b. Insulin injection &gt; 40 units per day? Yes/No</p> <p>c. How is it controlled?</p> <ul style="list-style-type: none"> <li>• diet</li> <li>• oral medication (list)</li> <li>• Insulin injection less than 40 units per day</li> </ul> <p><b>2. ANY TYPE OF CANCER?</b></p> <p>a. Date initially diagnosed?</p> <ul style="list-style-type: none"> <li>• Less than 1 year ago</li> <li>• 1-2 years ago</li> <li>• 3-5 years ago</li> <li>• Greater than 5 years ago</li> </ul> <p>b. Which organ(s) are involved?</p> <p>- Bone - Colon - Liver - Other(list)</p> <p>- Lung - Breast - Skin</p> <p>c. Initial treatment undertaken?</p> <p>- Surgery - Chemo</p> <p>- Radiation - Oral medication (list)</p> <p>d. Current treatment?</p> <p>- Oral medication (list) - Chemo</p> <p>- Radiation - Doctor exam – monthly</p> <p>- Doctor exam – annually - Palliative treatment</p> <p><b>3. A BLOOD DISORDER?</b></p> <p>a. Date initially diagnosed?</p> <ul style="list-style-type: none"> <li>• Less than 1 year ago</li> <li>• 1-2 years ago</li> <li>• 3-5 years ago</li> <li>• Greater than 5 years ago</li> </ul> <p>b. What was the specific diagnosis?</p> <p>- Anemia - Leukemia - Other (list)</p> <p>- Lymphoma - Polycythemia</p> <p>- Sickle cell anemia - Thalessemia [major/minor]</p> <p>c. Initial treatment undertaken?</p> <ul style="list-style-type: none"> <li>• Blood transfusion</li> <li>• Oral medications (list)</li> <li>• Phlebotomy</li> </ul> <p>d. Please indicate date of last blood transfusion (if any).</p> <ul style="list-style-type: none"> <li>• N/A (No Transfusion)</li> <li>• within 1 year</li> <li>• 1-3 years</li> <li>• Greater than 3 years</li> </ul> <p><b>4. A STROKE (CVA)?</b></p> <p>a. Date initially diagnosed?</p> <ul style="list-style-type: none"> <li>• Less than 1 year ago</li> <li>• 1-2 years ago</li> <li>• 3-5 years ago</li> <li>• Greater than 5 years ago</li> </ul> <p>b. Initial treatment undertaken?</p> <ul style="list-style-type: none"> <li>• TPA</li> <li>• Surgery</li> <li>• Hospitalization with medication</li> </ul> <p>c. Are you currently taking medication?</p> <ul style="list-style-type: none"> <li>• No/Yes (list)</li> </ul> <p>d. Any residual effects?</p> <p>- No - Paralysis - Weakness</p> <p>- Slurred speech - Difficulty swallowing</p> <p><b>5. CIRCULATORY PROBLEMS?</b></p> <p>a. Date initially diagnosed?</p> <p>- Less than 1 year ago</p> <p>- 1-2 years ago</p> <p>- 3-5 years ago</p> <p>- Greater than 5 years ago</p> <p>b. Specific diagnosis:</p> <p>- Peripheral Vascular Disease - Phlebitis</p> <p>- Deep vein thrombosis - Other (list)</p> <p>c. Initial treatment undertaken?</p> <ul style="list-style-type: none"> <li>• Surgery</li> <li>• Oral Medication (list)</li> </ul> <p>d. Current treatment? Yes/ No</p> | <p><b>EVER HAD:</b></p> <p><b>6. EPILEPSY?</b></p> <p>a. Date initially diagnosed?</p> <ul style="list-style-type: none"> <li>• Less than 1 year ago</li> <li>• 1-2 years ago</li> <li>• 3-5 years ago</li> <li>• Greater than 5 years ago</li> </ul> <p>b. Type of seizure?</p> <ul style="list-style-type: none"> <li>• Grand Mal</li> <li>• Petit Mal</li> <li>• Febrile</li> </ul> <p>c. Number of seizures in the past year?</p> <p>[0] [3-5]</p> <p>[1-2] [6 or more]</p> <p>d. Oral medication?</p> <p>- Dilantin - Phenobarbital</p> <p>- Other (list) - None</p> <p><b>7. BEEN DIAGNOSED WITH RHEUMATIC FEVER?</b></p> <p>a. Date initially diagnosed?</p> <ul style="list-style-type: none"> <li>• Less than 1 year ago</li> <li>• 1-2 years ago</li> <li>• 3-5 years ago</li> <li>• Greater than 5 years ago</li> </ul> <p>b. Do you have any of the following residual involvement/effects?</p> <p>- Joint - Brain</p> <p>- Heart - Skin - None</p> <p>c. Current treatment?</p> <p>- Aspirin - NSAID</p> <p>- IM injections - Prednisone</p> <p>- Other (list)</p> <p><b>8. BEEN DIAGNOSED WITH ABNORMAL BLOOD PRESSURE?</b></p> <p>a. Date initially diagnosed?</p> <ul style="list-style-type: none"> <li>• Less than 1 year ago</li> <li>• 1-2 years ago</li> <li>• 3-5 years ago</li> <li>• Greater than 5 years ago</li> </ul> <p>b. Type of abnormality?</p> <ul style="list-style-type: none"> <li>• High BP</li> <li>• Low BP</li> </ul> <p>c. Do you take oral medication?</p> <ul style="list-style-type: none"> <li>• No or Yes (list)</li> </ul> <p>d. Frequency of doctor visits?</p> <p>- N/A (Don't visit doctor)</p> <p>- Monthly or Quarterly or Annually</p> <p>e. Have your medications been adjusted?</p> <ul style="list-style-type: none"> <li>• N/A (Not taking medications)</li> <li>• Within last 6 months</li> <li>• Within last year</li> <li>• Greater than 2 years</li> </ul> <p>f. Any organs/systems affected by hypertension?</p> <p>- Heart - Kidney</p> <p>- Circulatory - None</p> <p><b>9. HEART TROUBLE?</b></p> <p>a. What type of heart trouble?</p> <p>- Heat Attack - Wolfe Parkinson White Syndrome</p> <p>- Arrhythmia - Chest Pain (Angina)</p> <p>- Slow heart rate - Fast heart rate</p> <p>b. Type of treatment?</p> <p>- Surgery – CABG - Stent Placement</p> <p>- Angioplasty - Heart Catheterization</p> <p>- Radiofrequency Ablation - Oral medication (list)</p> <p>c. Any chest pain within the last 6 months? Yes/No</p> <p>d. Chest pain relieved by?</p> <ul style="list-style-type: none"> <li>• Nitroglycerine</li> <li>• Rest</li> <li>• Other (list)</li> </ul> <p>e. Frequency of chest pain?</p> <ul style="list-style-type: none"> <li>• Weekly</li> <li>• Monthly</li> <li>• Greater than 6 months</li> <li>• N/A</li> </ul> <p>f. Have you been hospitalized within the last year for chest pain?</p> <p>Yes/No</p> |

**EVER HAD:**

**10. BEEN DIAGNOSED WITH TUBERCULOSIS?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Initial treatment undertaken?
  - Oral medication (list)
  - Chemotherapy
  - Surgical
- c. Any current treatment?
  - Oral medication (list)
  - Occasional CXR
  - None
- d. Other organ involvement?
  - Kidneys                    - Bones
  - Lymph Nodes            - None
- e. If you indicated an organ in the previous question, please indicate any current treatment.
  - Oral medication (list)
  - Surgery                    - Dialysis

**11. HAD OR HAVE OTHER LUNG PROBLEMS?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. What was the specific diagnosis?
  - Pneumonia
  - Collapsed Lung
  - Other (list)
- c. Initial treatment undertaken?
  - Oral Medication (list)
  - Hospitalization
  - IV medication
- d. Any current treatment? Please list.
- e. Total number of occurrences?  
[1] [2] [3] [More than 3]

**12. TESTED POSITIVELY FOR HIV, HAD KNOWN EXPOSURE TO AIDS OR HIV, OR RECEIVED TREATMENT FOR AIDS OR ARC?**

- a. How were you exposed?
  - Sexual or Casual contact
  - Contaminated blood, needle or syringe
- b. When exposed?
  - Less than 6 months
  - 6 months - 2 years
  - Greater than 2 years
- c. Have you ever had a blood test for HIV/AIDS, and if so, when?
  - Less than 6 months ago
  - 6 months - 2 years
  - Greater than 2 years
  - Never
- d. Test Results?
  - Positive or Negative or Not Applicable (No Test)

**13. BEEN DIAGNOSED WITH EITHER HEPATITIS OR A LIVER DISORDER?**

- a. Type of condition?
  - Hepatitis or Liver Disorder
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Diagnosis?
  - Hepatitis A                - Cirrhosis
  - Hepatitis B                - Elevated liver enzymes
  - Hepatitis C                - Fatty liver disease
  - Hepatitis D                - Other (list)
- d. Treatment?
  - Oral medication (list)
  - Doctor check-up every 6 months
  - Doctor check-up annually
  - Liver Biopsy
  - IV Medications
  - None

**IN THE LAST 5 YEARS, HAS ANYONE APPLYING FOR COVERAGE:**

**14. BEEN DIAGNOSED WITH ASTHMA, BRONCHITIS OR SINUS TROUBLE?**

- a. Type of condition?
  - Asthma                    - Bronchitis
  - Sinus trouble            - RSV
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Has emphysema or COPD ever been diagnosed?  
Yes/No
- d. Have you ever been hospitalized? Yes/No
- e. Have you been treated in an outpatient clinic in the last two years? Yes/No
- f. Number of attacks/episodes over the last 2 years?  
[0] [3-4]  
[1-2] [5 or more]
- g. Current treatment?
  - Surgery                    - Oral medication (list)
  - Inhalers                    - Nebulizers
  - Oxygen                    - None

**15. BEEN DIAGNOSED WITH ALLERGIES?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. What is this person allergic to?
  - Dust                        - Food
  - Pollen                      - Other (list)
- c. Manifestation of allergy?
  - Watery eyes                - Runny nose
  - Difficulty breathing      - Coughing
  - Wheezing                  - Other (list)
- d. Have you ever been hospitalized for this?  
Yes/No
- e. Number of attacks over the past two years?  
[0] [3-4]  
[1-2] [5 or more]
- f. Current treatment?
  - Allergy injections (include frequency)
  - Medications (list)

**16. BEEN TREATED FOR ARTHRITIS?**

- a. Date initially diagnosed
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Type of arthritis?
  - Osteo or Rheumatoid
- c. Have you ever been hospitalized for this condition?  
Yes/No
- d. Treatment?
  - Oral medication (list)    - Steroid injections
  - Surgical                    - Treat only acute attacks
  - Other (list)
- e. Has surgery been recommended or performed?  
Yes or No

**17. BEEN TREATED FOR RHEUMATISM/BURSITIS, OR SCIATICA?**

- a. Type of condition?
  - Rheumatism/Bursitis
  - Sciatica
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Have you ever been hospitalized for this condition?  
Yes/No
- d. Treatment?
  - Oral medication (list)    - Steroid injections
  - Surgical                    - Treat only acute attacks
  - Other (list)
- e. Has surgery been recommended or performed?  
Yes/No

**18. HAD ANY BODILY DEFORMITIES?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Is the deformity
  - Congenital
  - Result of an illness
  - Result of an accident
- c. Is the deformity correctable?  
Yes/No
- d. If yes, was it corrected?  
- N/A (Not Correctable)  
- Yes/No

**19. HAD ANY BACK/ORTHOPEDIC CONDITION OR MUSCULAR DISEASES?**

- a. Type of condition?
  - Back/orthopedic problems
  - Muscular diseases.
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Specific diagnosis?
 

|                          |                          |
|--------------------------|--------------------------|
| - Ruptured disc          | - Herniated disc         |
| - Fracture (broken bone) | - Carpal Tunnel Syndrome |
| - Torn rotator cuff      | - Bursitis               |
| - Osteoporosis           | - Other (list)           |
- d. Have you ever been hospitalized for this condition?  
Yes/No
- e. Was surgery recommended?  
Yes/No
- f. Was surgery performed?  
Yes/No
- g. Treatment?
  - Chiropractor (include frequency)
  - Physical Therapy
  - Medications (list)

**20. HAD ANY KNOWN TUMORS OR CYSTS?**

- a. Specific diagnosis?
 

|                  |                              |
|------------------|------------------------------|
| - Sebaceous Cyst | - Fibrocystic breast disease |
| - Lipoma         | - Uterine Fibroid Tumors     |
| - Other tumor    | - Other cyst (list)          |
- b. Specific location?
- c. Was it surgically removed?  
Yes/No
- d. When was it removed?
  - N/A (Not Removed)
  - Less than 1 year ago
  - 1-2 years ago
  - 2-3 years ago
  - Greater than 3 years ago
- e. Is any future treatment anticipated?
  - N/A (removed)
  - Yes/No
- f. Is it, or was it, benign?  
Yes/No

**21. BEEN TREATED FOR ANY KIDNEY/URINARY, DIABETES INSIPIDUS, OR PROSTATE DISORDERS?**

- a. Type of condition?
 

|                          |                     |
|--------------------------|---------------------|
| - Kidney stones          | - Bladder infection |
| - Diabetes Insipidus     | - Prostate disorder |
| - Renal (kidney) failure | - Other (list)      |
- b. Please describe the disorder.
 

|                         |                              |
|-------------------------|------------------------------|
| - Interstitial cystitis | - Polycystic kidney disease  |
| - Kidney stones         | - Bladder infection/cystitis |
| - Diabetes insipidus    | - Prostate disorder          |
| - Renal/Kidney failure  | - Elevated PSA               |
| - Prostatitis           | - Fertility treatments       |
| - Other (list)          |                              |
- c. Date initially diagnosed?
  - Within 1 year
  - 1-2 years
  - 3-5 years
  - Greater than 5 years

**21. continued**

- d. Number of occurrences in the past 2 years?  
[0] [1-2] [3-5] [6 or more]
- e. Have you ever been hospitalized for this?  
Yes/No
- f. Was surgery recommended?  
Yes/No
- g. Was surgery performed?  
Yes/No
- h. Do you currently take medication for this?  
Yes (list)/No

**22. BEEN DIAGNOSED WITH AN ENDOCRINE DISORDER, THYROID PROBLEM, OR GOITER?**

- a. Type of condition?
 

|                    |                      |
|--------------------|----------------------|
| - Thyroid disorder | - Endocrine disorder |
| - Goiter           | - Graves Disease     |
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Problem due to?  
Underactive or Overactive
- d. Treatment?
 

|                |             |
|----------------|-------------|
| - Surgical     | - Radiation |
| - Other (list) | - None      |

 \* please list oral medication
- e. Was a biopsy performed? Yes/No

**23. BEEN TREATED FOR HEMORRHOIDS/RECTAL AILMENTS, OR VARICOSE VEINS?**

- a. Type of condition?
 

|               |                         |                  |
|---------------|-------------------------|------------------|
| - Hemorrhoids | - Other rectal ailments | - Varicose Veins |
|---------------|-------------------------|------------------|
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Was surgery recommended?  
Yes/No
- d. Was surgery performed?  
Yes/No
- e. Any reoccurrence since surgical correction?  
Yes/No

**24. HAD A HERNIA?**

- a. Type of condition?
 

|            |             |         |
|------------|-------------|---------|
| - Inguinal | - Umbilical |         |
| - Hiatal   | - Ventral   | - Other |
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Was surgery recommended? Yes/No
- d. Was surgery performed? Yes/No
- e. Any reoccurrence since surgical correction? Yes/No/N/A
- f. eblue additional comments field available.

**25. HAD SEIZURES, FAINTING SPELLS?**

- a. Type of condition?
 

|             |                   |
|-------------|-------------------|
| - Seizures  | - Fainting Spells |
| - Headaches | - Migraines       |
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Was there a loss of consciousness?
  - N/A or Yes or No
- d. Were you treated by a physician? Yes/No
- e. Number of episodes in the last 2 years?  
[0] [1-2] [3-5] [6 or more]
- f. Please list any oral medications.
 

|                |                 |
|----------------|-----------------|
| - Dilantin     | - Phenobarbital |
| - Imitrex      | - Fiorinal      |
| - Other (list) | - None          |

**26. HAD HEADACHES?**

- a. Type of condition?
  - Migraines, Cluster, Tension (Primary)
  - Other Headaches (Secondary)
- b. Date Initially Diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Frequency of headaches?
  - daily - weekly - monthly - other
- d. Treatment?
  - Daily medications (oral)
  - PRN medication (as needed)
  - Combination of medications
  - Other
- e. Additional comments field on eblue

**27. HAD IRREGULAR/EXCESSIVE MENSTRUAL BLEEDING?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Cause of illness?
  - Menopause
  - Hormone imbalance
  - Other (list)
- c. Treatment?
  - Oral medications (list)
  - Surgical consult
  - Surgery
  - Other or None

**28. HAD ANY OTHER FEMALE REPRODUCTIVE PROBLEMS?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Type of disorder?
  - Endometriosis - Prolapse of uterus
  - Abnormal PAP smear - Uterine fibroid tumor
  - Fertility treatment - Ovarian cyst
  - Adhesions - Tilted Uterus
- c. Was surgery recommended? Yes/No
- d. Was surgery performed? Yes/No
- e. Has there been any reoccurrence since surgery? Yes/No
- f. Has there been any followup treatment?
  - Yes/No
  - N/A (No treatment)

**29. HAD PELVIC PAIN?**

- a. Please indicate who has this condition.
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Type of disorder?
  - Endometriosis - Dysmeronhea
  - Ectopic Pregnancy - Ovarian cysts or masses
  - Pelvic inflammatory disease - Adhesions
  - Retroversion of uterus - other
- d. Treatment rendered?
  - Surgery/Removal/correction
  - Observation only - Diagnostic procedures (list)
  - Other - Medication
- e. Has the pain resolved? Yes/No
- f. Have you had any complications resulting from this illness? Yes/No
- g. Additional comments field available on eblue.

**30. HAD GALL STONES, A GALL BLADDER DISORDER?**

- a. Type of condition?
  - Gallstones - Gallbladder disorder
  - Pancreatitis - Reflux Disease
  - Ulcers - Other (list)
  - Abdominal Pain
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Treatment? - Oral medication (list) - Surgical
- d. Please describe any dietary restrictions since surgery. Yes (describe) or No or None

**31. HAD ABDOMINAL PAIN?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Type of disorder?
  - Reflux esophagitis - Ulcer disorder (stomach)
  - Colon disorder - Intestinal disorder
  - Female disorders (answer paper app #15)
  - Bladder disorders (answer paper app #11)
  - Other
- c. Treatment rendered?
  - Surgery/Removal/correction
  - Observation only - Diagnostic procedures (list)
  - Other - Medication
- d. Has pain resolved? Yes/No
- e. Have you had any complications resulting from this illness? Yes/No
- f. Additional comment field available on eblue.

**32. HAD ULCERS, STOMACH, COLON OR OTHER INTESTINAL DISORDERS, OR ADHESIONS?**

- a. Type of condition?
  - Ulcers - Stomach Disorder
  - Colon Disorder - Intestinal Disorder
  - Adhesions
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Type of problem?
  - Reflux - Ulcers
  - Polyps - Diverticulitis
  - Diverticulosis - Obstruction
  - Adhesions - Irritable bowel syndrome
  - Crohn's disease - Other (list)
- d. Treatment?
  - Surgery - Oral medications (list)
  - Special diet - Other (list) - None
- e. Please describe any re-occurrences since surgery or N/A

**33. HAD ANY EYE CONDITIONS?****(EXCLUDING CORRECTIVE LENSES)**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Type of impairment?
  - Glaucoma - Cataracts
  - Retinal detachment - Macular degeneration
  - Lattice degeneration - Strabismus
  - Other (list)
- c. Which eye was affected? Left or Right or Both
- d. Treatment?
  - Use of medications
  - Surgery
- e. Did you have lens implants? Yes/No

**34. HAD ANY EAR CONDITION OR IMPAIRMENT?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Type of disorder?
  - Impairment of hearing      - Ear infections
  - Motion sickness              - Meniere's disease
- c. Treatment?
  - Use of medications (list)      - Surgery
  - Hearing aids                      - Other (list)
- d. Any tubes/buttons currently present? Yes/No

**35. HAD A MENTAL/NERVOUS DISORDER(INCLUDING EATING DISORDERS), OR ANY PSYCHIATRIC/PSYCHOLOGICAL CONSULTATIONS?**

- a. Type of condition?
  - Mental/nervous disorder
  - Consultations
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Type of disorder?
  - Anxiety                              - Depression
  - Obsessive-compulsive          - Schizophrenia
  - Manic depressive                - Autism
  - Alzheimers                         - Anorexia/Bulimia
  - ADD                                    - Post-traumatic stress
  - Other (list)
- d. Have you ever been hospitalized for this condition? Yes/No
- e. When was your last hospital stay for this condition?
  - N/A (Not Hospitalized)
  - Less than 6 months ago
  - 6 months - 2 years ago
  - Greater than 2 years ago
- f. Number of hospital stays in the last two years?  
[0]                              [3-4]  
[1-2]                            [5 or more]
- g. Do you take oral medications? If yes, please list. Yes (list)/No

**36. HAD CANDIDIASIS (YEAST INFECTION), HERPES, SYPHILIS, GONORRHEA, CONDYLOMATA ACUMINATA (GENITAL WARTS), OR OTHER SEXUALLY TRANSMITTED DISEASES?**

- a. Type of condition?
  - Candidiasis                        - Herpes
  - Syphilis                              - Gonorrhea
  - Genital Warts                      - Other STD
- b. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- c. Type of illness?
  - Yeast infection                    - Genital warts
  - Trichomoniasis                  - Herpes
  - Gonorrhea                         - Syphilis
  - Other
- d. Was it treated with medications? Yes/No
- e. Has this condition reoccurred since treatment? Yes/No
- f. Have you had any complications resulting from this illness? Yes/No

**37. SUFFERED FROM OR RECEIVED TREATMENT FOR ALCOHOL OR SUBSTANCE ABUSE OR DETOXIFICATION?**

- a. Date initially diagnosed?
  - Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - Greater than 5 years ago
- b. Was your treatment, if any, in-patient? Yes/No
- c. Have you had any medical problems resulting from the use of alcohol or drugs? Yes/No

**38. HAD ANY CONDITION (INCLUDING DEVELOPMENTAL DEFECTS OR DEFORMITIES) OF ORAL CAVITY, JAW, FACIAL OR CRANIAL BONES, TEETH, OR SURROUNDING STRUCTURES?**

- a. Type of condition?
  - Oral Cavity                        - Jaw
  - Facial/Cranial                    - Teeth
- b. Specific diagnosis?
  - Wisdom teeth removed
  - TMJ
  - Receding chin
  - Overbite/Underbite
  - Nose reconstruction
  - Other (list)
- c. Any treatment planned, or any surgery scheduled? Yes/No

**39. ARE YOU OR YOUR SPOUSE CURRENTLY PREGNANT?**

- a. Please indicate who has this condition.
- b. Due date?
- c. Additional comment field available on eblue.

**40. USED TOBACCO IN ANY FORM WITHIN THE LAST 12 MONTHS?**

- a. Form of tobacco?
  - Cigarettes
  - Cigars
  - Chewing tobacco
  - Snuff
- b. How long have you used tobacco?
  - Less than 2 years
  - 2-6 years
  - Greater than 6 years
- c. Amount Used?
  - Less than 1 pack/day or 1 can/day
  - Greater than 1 pack/day or 1 can/day
  - Other (list)
- d. Have you been advised or any tobacco related health problems?
  - No                                    - Cancer                    - Respiratory problems
  - Disorder of lips, gums, and/or mouth

**41. PRESENTLY TAKING MEDICATIONS FOR CONDITIONS NOT MENTIONED IN OTHER QUESTIONS? – Make a list of all other medications that anyone on the application is taking.**

**42. IS ANYONE ENGAGED IN PRIVATE FLYING, PARACHUTING, HANG GLIDING, RACING, UNDERWATER DIVING, HANDLING OF EXPLOSIVE MATERIALS, HARZARDOUS WASTES OR MATERIALS?**

- a. Type of activity?
  - Private Flying                    - Parachuting
  - Hang Gliding                    - Racing
  - Diving                              - Handling of explosive materials
- b. Frequency?
  - Daily                                - Weekly
  - Monthly                            - Every 3-6 months
  - Annually
- c. Professional or Amateur?
- d. Employment related, or recreational?

**43. HAS ANYONE EVER HAD ANY HEALTH INSURANCE POSTPONED, RATED, RIDERED, DECLINED, CANCELLED OR HAD REINSTATEMENT REFUSED?**

- a. Which action was taken?
  - Postponed
  - Rated
  - Ridered
  - Declined
  - Canceled
  - Reinstatement refused
- b. Rationale?
  - Lack of payment
  - Medical condition
  - Misrepresentation
- c. When was the action taken?
  - Less than 2 years ago
  - 2-6 years ago
  - More than 6 years ago
- d. If this was caused by a medical condition, please specify that condition (or N/A if not).
- e. Was this done with Blue Cross & Blue Shield of Louisiana? Yes/No

**44. ANY DEPARTURE FROM GOOD HEALTH OR ANY MEDICAL OR SURGICAL ADVICE OR TREATMENT FROM ANY MEDICAL PRACTITIONER (MEDICAL DOCTOR/SURGEON PODIATRIST, OPTOMETRIST, CHIROPRACTOR, DENTISTS/ORAL SURGEONS, ETC.) IN THE LAST 5 YEARS?**

- a. Specific diagnosis?
- b. Date initially diagnosed?
  - Within 1 year
  - 1-2 years
  - 3-5 years
  - Greater than 5 years
- c. Have you been hospitalized for this condition?  
Yes/No
- d. Was surgery recommended or performed?  
Yes/No
- e. Are you currently being treated for this?  
Yes/No