SHORT FORM HEALTH QUESTIONNAIRE

	First Name	Last Name	Age	Height (ft & in.)	Weight (lb.)	Gender (M/F)	Any tobacco use in the past 12 months? (Y/N)
Insured							
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							
Dependent							
Dependent							

Question	Answer
1. Are you or any dependent to be covered: a. Currently pregnant or have reason to suspect you might be pregnant?	Y☐ N☐
b. Financially responsible for an unborn child, anticipating adoption, applying for adoption, or have applied for adoption?	Y☐ N☐
2. In th past 24 months, have you or any dependent to be covered been recommended or scheduled for diagnostic testing, treatment, or surgery that has not been completed?	Y☐ N☐
3. Within the past 24 months, have you or any dependent to be covered had a health related condition for which you have not sought medical advice or treatment?	Y☐ N☐

4. Within the past five years, have you or any dependent to be covered received any abnormal test results, medical or surgical treatment, healthcare professional consultation, or prescribed medication for any of the following conditions? **(Check all that apply.)**

- ☐ Arthritis, Reumatologic disorder, or any disease/disorder of the joints, bones, muscles, or back
- ☐ AIDS or tested positive for HIV
- ☐ Asthma, Emphysema, COPD, TB, or any other disease or disorder of the respiratory system
- ☐ Cardiovascular disease or disorder of the heart, arteries, blood vessels or blood
- ☐ Cancer or tumor
- ☐ Chemical dependency, drug or alcohol abuse, or any other mental health disease or disorder
- ☐ Crohn's disease, ulcerative colitis, hepatitis, or any other disorder of the liver, stomach, colon, or intestines
- ☐ Diabetes or any other disorder of the pancreas
- ☐ Immune system disease or disorder
- ☐ Kidney disease or disorder
- ☐ Neurological system disorder
- ☐ Stroke

If you answered yes to any of the above questions, please explain, including: name of person, date of condition, condition treatments, medications, expected future treatments, and other information to better understand your needs. You may use the space below the table if needed.

Name of Person	Date of Incident and/or Last Treatment	Explain Condition	Explain Treatment

I certify that the above information is true to the best of my knowledge. I understand that this may become part of an application for health insurance and is subject to the Utah code regarding such applications.

Signature: ______________________________ Date: ______________

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