



Individual Health Risk Questionnaire (HRQ)

Health Net®

Instructions: The questions below apply to each employee and dependents that are applying for coverage listed on this application. They apply to both past and present conditions or symptoms. Answer each question truthfully and completely. Attach a piece of paper if you need more space. Complete every item even if the answer is "no." We consider the answer to each question to be material to the risk Health Net assumes in extending health care coverage. Applications will be returned if all questions are not answered completely.

Genetic Information Non-discrimination Act of 2008 (GINA) Compliance Statement: This Health Risk Questionnaire (HRQ) is not a request for genetic information. In answering these questions you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.

Please fill in: **Company Name** _____

	First Name	Last Name	Sex M/F	DOB	Height	Weight	Tobacco Use Within Last 12 Months Y/N	Name of Primary Physician	Physician's Phone Number
Employee									
Spouse									
Children									

Please check any condition, treatment or care mentioned below that applies. All questions must be answered. For Yes, please provide detail in section 5. 1 Indicate if you or any listed dependents have ever suffered from, or received care, counseling or been advised for any of the following:

- | | | | | | |
|---------------------------|--|------------------------|--|-----------------------------------|--|
| Alcohol/Drug use or abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS/HIV or ARC | <input type="checkbox"/> Yes <input type="checkbox"/> No | Immune system disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back or Spine disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/Renal disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Paralysis/Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer or Tumor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory/Lung disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Digestive/Bowel disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No | Last Reading (systolic/diastolic) | _____ |

2) Is female applicant, spouse or any dependent now pregnant? Yes No Due date: _____

If yes, name and relationship

Are complications anticipated? Yes No Multiple birth? Yes No

Prior history of miscarriage, therapeutic abortions, stillbirth, cesarean section or other complication of pregnancy? Yes No

Any congenital anomalies or health complications with previous newborns? Yes No.

Any congenital anomalies or health complications with current fetus? Yes No.

Any problems, including vaginal bleeding, with pregnancy? Yes No

3) Have any applicant(s) been counseled or advised that they have or may have any disease, disorder, impairment, deformity, injury, or any chronic or untreatable condition whether active or in remission? Yes No

4) Have any applicant(s) had medical or surgical consultation, advice, or treatment (including medication) for any condition(s) during the past 36 months? Yes No

5) If you have checked Yes, for any item in sections 1-4, please explain below (use additional sheet of paper if necessary)

Patient's Name	Diagnosis/Condition Requiring Treatment	Treatment	Physician	Physician's Phone Number	Date of Illness (mo/yr)	Was recovery complete ?

6) Have you or any listed dependents taken or used any medication or drug within the past 12 months? Yes No

If yes, please explain below. (Use extra sheet of paper if necessary.)

Patient's Name	Medication Name	Condition Requiring Medication	Still Taking? Y / N

7) Has the applicant or any listed dependent ever been denied insurance coverage? Yes No If yes, explain:

