Personal Health Questionnaire (PHQ)

Employee Name: _____ **Employer Name:** _____

Daytime Phone: ( ) - _____ **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 p. 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		Weight (lbs)	Home Zip Code	Tobacco use in last year? (Yes / No)
					ft.	in.			
1	Employee								
2	Spouse								
3	Child								
4	Child								
5	Child								
6	Child								

II. Medical Conditions & Treatments

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 p. 2 for ALL "Yes" answers.**

1. Cancer (if yes, list location and type of cancer below) **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, or
___ bypass surgery or angioplasty on **multiple** vessels;
___ **ANY other heart conditions (list here):** _____
(i.e. 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 (i.e. rheumatoid, osteo, psoriatic, gout)	☐	☐
7. Autoimmune Disease (i.e. lupus, MS, anemia)	☐	☐
8. Back Disorder (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain)	☐	☐
9. Benign Growth (i.e. tumor, cyst)	☐	☐
10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis)	☐	☐
11. Circulatory System Disease (i.e. stroke, arterial / vascular diseases)	☐	☐
12. Immunodeficiency (i.e. AIDS, HIV+, hemophilia)	☐	☐
13. Kidney Disorder (i.e. nephritis, renal failure)	☐	☐
14. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E)	☐	☐
15. Mental Illness (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia)	☐	☐
16. Counseling Current or prior counseling?	☐	☐
17. Muscular Disorder	☐	☐
18. Respiratory (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis)	☐	☐
19. Stomach (i.e. ulcer, acid reflux, GERD)	☐	☐
20. Substance dependency (i.e. alcohol, drug)	☐	☐
21. Transplants (if yes, list organ(s): _____)	☐	☐

II. Medical Conditions & Treatments (continued)

	Yes	No
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. Is 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?	☐	☐

Reminder:
Please complete ADDITIONAL DETAIL TABLE for **ALL** items answered "YES" on Pages 1 & 2

III. Pregnancy 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) Previous c-section or pre-term birth?	☐	☐
d) Are multiple births expected? If so, please check one: **__twins ___triplets ___more**		

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? (Y / N)	Degree of Recovery

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

In the event that information has been intentionally omitted or misrepresented, the insurance carrier may deny or limit coverage, furthermore, the service agreement may terminate for breach. In such cases, I understand the PEO or the carrier may change my insurance premiums. I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage.

The PEO gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment. Prospective employees in Michigan should not provide information regarding height or weight. In compliance with requirements for GINA, The PEO is not requesting genetic information.

I will notify the PEO of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the health plan.

Employee SIGN HERE and Date:

➡ _____ Date: _____