Personal Health Questionnaire (PHQ)

Employee Name:						Employer Name:					
Daytime Phone: () -						Date of Hire:					
Address: City:			s	tate: Zip:	ip: E		Email Address:				
		,		's health insurance	•		Yes	□ No			
		00	Covered b	lowing, then skip the by Spouse's plan ant Coverage	<u>remainder</u>	r of the form and sig ☐ Not Eligible ☐ Other Reaso			- ")
· Ans · Incli · All c	wer the following ude additional sl questions must b	heets for detailed e be answered or the	rself and eligible xplanations or a form may not b	e enrolling family memb dditional dependents.	ers.						
I. De	emographic,	Build and Toba	cco Use				1				
	Relation to	Member	Name	Social Security Number	Gender	Date of Birth	Н	eight	Weight	Home Zip	Tobacco use in last year?
	Employee			,	(M/F)	(mm/dd/yyyy)	ft.	in.	(lbs)	Code	(Yes/No)
1	Employee										
2	Spouse										
3	Child										
4	Child										
5	Child										
6	Child										
***	Check "YES"	=	ch question.	g, within the last <u>5 v</u> Please complete of Yes		NAL DETAIL TAE	SLE on p	. 3 for <u>A</u>	<u>LL</u> "Yes" a	answers. Yes	No
	Location and type of cancer					6. Arthritis (i.e. r	neumatoid,	osteo, psor	iatic, gout)		
Check one: Stage 1, Stage 2, Stage 3, higher				higher		7. Autoimmune	Disease (i.e. lupus, M	IS, anemia)		
Date of remission (if applicable):					8. Back Disorde						
		art Disease / Disoi	rder	Yes	No	herniated dis			ylitis, strain)		
	If yes, check all	,				9. Benign Grow	•				
heart attack,					10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis)						
bypass surgery or angioplasty on single vessel, or						11. Circulatory System Disease (i.e. stroke, arterial / vascular diseases)					
bypass surgery or angioplasty on multiple vessels; ANY other heart conditions (list here):						12. Immunodefici		•	. hemophilia)		
(i.e. arrhythmia, aneurysm, heart failure, heart valve disorder)					13. Kidney Disor	• ,					
3.	Diabetes (if yes	. list type 1 or 2)	,	Yes	No	14. Liver Disease	(i.e. cirrho	sis. hepatitis	s A. B. C. E)		
	Type:					15. Mental Illness	•	•			
	ır yes, ııst 3 most	recent HDA1c / fastii	ng blood sugar lev	/eis:		anxiety, pipo	ıar disorde	r, or scnizop	nrenia)		
	1)	2)	3)			16. Counseling C	urrent or p	rior counseli	ing?		
4.	High Choleste	rol		Yes	No	17. Muscular Dis	order				
	If yes, list 3 most	_				18. Respiratory (i			neumonia,		
-	1)	2)	3)			COPD, emp			D)		
5.	High Blood Pre			Yes	No	19. Stomach (i.e.					
	If yes, list 3 most	_	2)			20. Substance de			oi, drug)		
	1)	2)	3)			21. Transplants (ıyes, list 0	ryan(s)			

II. Modical Conditions & Treatments (continued)									
23. Has anyone had any of the following for a serious illness in the past 5 years? a) readment. b) hoppistization. c) surgery. 24. Is anyone currently. a) bopistization. b) confined in home, inexpeciated or incorpiable of self-support?. 25. Is anyone currently. b) confined in home, inexpeciated or incorpiable of self-support?. 26. Is the past 5 years, has anyone enrolling had symptoms of any serious medical condition on byte indicated on this form? 27. Is anyone pregnant? (In c. mark "No" and skip question 27.) 28. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition on byte indicated on this form? 29. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition on byte indicated on this form? 20. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition on byte indicated on this form? 21. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition on byte indicated on this form? 22. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition on byte indicated on this form? 23. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition on byte indicated on this form? 24. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition on byte indicated on this form? 25. Privatious cooling or pre-lemm this form? 26. In the past 5 years, has anyone programment, and the past 5 years of the past 5 y	II. Medi	cal Conditions & Tre	eatments (continued)		Yes	No			
a) treatment. b) hospitalization or confined in a treatment facility? c) surgery. 2. Is anyone currently: a) hospitalization or confined in a treatment facility? b) confined at home, incapacitated or incapable of self-support? 2. Is anyone currently: a) hospitalization or confined in a treatment facility? b) confined at home, incapacitated or incapable of self-support? 2. Is anyone currently: a) hospitalization. c) surgery. 2. Is they past 5 years, has anyone enrolling had symptoms of any serious modical condition not yet indicated on this form? III. Pregnancy and Childbirth 2. Is anyone pregnant? (if no mark 'No' and skip question 27.)	22. Is an	nyone currently taking pr	escription medication(s	?				D	t.
a) itemmet. c) surgery. 2. Is anyone currently: a) hospitalization b) confined at hose, incapacitated or incapable of self-support? b) confined at hose, incapacitated or incapable of self-support? 2. Is any of the following pending? b) confined at hose, incapacitated or incapable of self-support? 2. Is any of the following pending? b) hospitalization c) surgery. 2. In the past Sysars, has anyone enrolling had symptoms of any serious medical condition may be indicated on this form? 2. Is anyone pregnant? (fine, mark 'No' and skip question 27.) a) The due date is: b) Is this a High Rat Pregnancy, any complications or bleeding? c) Previous ceacition or pre-form birth? 2. Is anyone pregnant? (fine, mark 'No' and skip question 27.) b) Is this a High Rat Pregnancy, any complications or bleeding? c) Previous ceacition or pre-form birth? 3. In the past Sysars, has enjoine or force or the previous ceacition or pre-form birth? 4. In the due date is: b) Is the a High Rat Pregnancy, any complications or bleeding? c) Previous ceacition or pre-form birth? 5. In anyone predictor or force the previous ceacition or pre-form birth? 6. Onesting Name of Individual Condition / Diagnosis Date of Onset Lest Date Treaded Treatment / Drug Story 8. If you marked "Yes" to any Item on Pages 1 & 2, please complete ADDITIONAL DETAIL TABLE 8. Boove, or this form will not be accopted. 1. Incore verification 1. In the section of the application will city be used for the purpose of determining eligibility for policer accordance for the range of your household simual moore. 2. Each Story	23 . Has	anyone had any of the f	ollowing for a serious illr	ess in the past 5 years?			DI		-
b) hospitalization. 24. Is any one currently: 30 hospitalization contined in a treatment facility? 31 hospitalization contined in a treatment facility? 32 hospitalization contined in a treatment facility? 33 treatment (modical toeatment or diagnostic tostings) 34 treatment (modical toeatment or diagnostic tostings) 35 hospitalization on the facility of the	a) tı	eatment							
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26. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition not yet indicated on this form?	b) h	ospitalization							
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a) The due date is: b) Is this a High Risk Pregnancy, any complications or bleeding?						No			
b) Is this a High Risk Pregnancy, any complications or bleeding? c) Previous c-section or pre-term birth? d) Are multiple brits expected? If so, please check one twins triplets more ADDITIONAL DETAIL TABLE - Please Fill In Details Below For All Questions Answered "YES" Question y Name of Individual Condition / Diagnosis Date of Onset Last Date Treatment / Drug tsking? Treated Treatment / Drug tsking? (Y/N) **If you marked "Yes" to any item on Pages 1 & 2, please complete ADDITIONAL DETAIL TABLE above, or this form will not be accepted. Income Verification Income Verification This section of the application will only be used for the purpose of determining eligibility for patient assistance programs which are designed to provide you with low cost or no cost medications. Participation may also save you money on copsyments and/or deductibles. Please indicate the range of your household annual income. \$25K-\$50K \$350K-\$75K \$75K-\$100K \$100K \$100K-\$150K \$100K \$				ion 27.)					
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Thank you for completing the requested information above. Any non-public personal health information (i.e., name with address and/or social security number and detailed health information) (protected health information) that you provide via hard copy or through this process. This application will be used be solely for the purpose of providing risk assessment to Triad that will provide a health care benefit quote to your employer. Triad's actuary and underwriter are acting as a Business Associate and are subject to certain provisions of the Health insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Conquers actuary and underwriter will not self, license, transmit or disclose this information outside of their offices except as: a) necessary for them to provide the services on behalf of the plan, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.