BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

MEDICAL GUIDE QUESTIONNAIRE

NUMBERING FOR EBLUE MEDICAL QUESTIONS

EVER HAD:

1. DIABETES MELLITUS?

a. Date initially diagnosed?
- Less than 1 year ago
- 1-2 years ago
- 3-5 years ago
- Greater than 5 years ago
- Juvenile onset

b. Insulin injection > 40 units per day? Yes/No

c. How is it controlled?
- diet
- oral medication (list)
- Insulin injection less than 40 units per day

2. ANY TYPE OF CANCER?

a. Date initially diagnosed?
- Less than 1 year ago
- 1-2 years ago
- 3-5 years ago
- Greater than 5 years ago

b. Which organ(s) are involved?
- Bone - Colon - Liver - Other(list)
- Lung - Breast - Skin

c. Initial treatment undertaken?
- Surgery - Chemo
- Radiation - Oral medication (list)

d. Current treatment?
- Oral medication (list) - Chemo
- Radiation - Doctor exam – monthly
- Doctor exam – annually - Palliative treatment

3. A BLOOD DISORDER?

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?
- Anemia - Leukemia - Other (list)
- Lymphoma - Polycythemia
- Sickle cell anemia - Thalessemia [major/minor]

c. Initial treatment undertaken?
- Blood transfusion
- Oral medications (list)
- Phlebotomy

d. Please indicate date of last blood transfusion (if any).
- N/A (No Transfusion)
- within 1year
- 1-3 years
- Greater than 3 years

4. A STROKE (CVA)?

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?
- TPA
- Surgery
- Hospitalization with medication

c. Are you currently taking medication?
- No/Yes (list)

d. Any residual effects?
- No - Paralysis - Weakness
- Slurred speech - Difficulty swallowing

5. CIRCULATORY PROBLEMS?

a. Date initially diagnosed?
- Less than 1 year ago
- 1-2 years ago
- 3-5 years ago
- Greater than 5 years ago

b. Specific diagnosis:
- Peripheral Vascular Disease - Phlebitis
- Deep vein thrombosis - Other (list)

c. Initial treatment undertaken?
- Surgery
- Oral Medication (list)

d. Current treatment? Yes/ No

NUMBERING FOR EBLUE MEDICAL QUESTIONS

EVER HAD:

6. EPILEPSY?

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 seizure?
- Grand Mal
- Petit Mal
- Febrile

c. Number of seizures in the past year?
[0] [3-5]
[1-2] [6 or more]

d. Oral medication?
- Dilantin - Phenobarbital
- Other (list) - None

7. BEEN DIAGNOSED WITH RHEUMATIC FEVER?

a. Date initially diagnosed?
- Less than 1 year ago
- 1-2 years ago
- 3-5 years ago
- Greater than 5 years ago

b. Do you have any of the following residual involvement/effects?
- Joint - Brain
- Heart - Skin - None

c. Current treatment?
- Aspirin - NSAID
- IM injections - Prednisone
- Other (list)

8. BEEN DIAGNOSED WITH ABNORMAL BLOOD PRESSURE?

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 abnormality?
- High BP
- Low BP

c. Do you take oral medication
- No or Yes (list)

d. Frequency of doctor visits?
- N/A (Don't visit doctor)
- Monthly or Quarterly or Annually

e. Have your medications been adjusted?
- N/A (Not taking medications)
- Within last 6 months
- Within last year
- Greater than 2 years

f. Any organs/systems affected by hypertension?
- Heart - Kidney
- Circulatory - None

9. HEART TROUBLE?

a. What type of heart trouble?
- Heat Attack - Wolfe Parkinson White Syndrome
- Arrhythmia - Chest Pain (Angina)
- Slow heart rate - Fast heart rate

b. Type of treatment?
- Surgery – CABG - Stent Placement
- Angioplasty - Heart Catheterization
- Radiofrequency Ablation - Oral medication (list)

c. Any chest pain within the last 6 months? Yes/No

d. Chest pain relieved by?
- Nitroglycerine
- Rest
- Other (list)

e. Frequency of chest pain?
- Weekly
- Monthly
- Greater than 6 months
- N/A

f. Have you been hospitalized within the last year for chest pain?
Yes/No

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 ag0

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)
- Growths and Wart

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 than3 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 1year
- 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 - Endorcrine 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-occurences 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	