Kismet Risk Management Associates Medical Questionnaire:

Group Name:____
Proposed Effective Date: ____
Member Name:____
Date of Birth:______________________ **Gender**: **Male** **Female**

1. Are you presently hospitalized, or scheduled for, in need of, or have been advised that you should have hospitalization or surgery? Yes No

If yes, please provide details:

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2. Have you ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV), or any other
Immune System Disorder? Yes No

If yes, please provide details including drug names, dosage amount, and frequency taken:

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3. Have you ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)? Yes No

If yes, please provide details:

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4. Heart, cardiac, cardiovascular, and/or circulatory, including but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? Yes No

If yes, please provide details:

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5. Blood, blood vessels, spleen, arteries, veins, or disorders of the blood, including but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?
Yes No

If yes, please provide details:

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6. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind? Yes No

If yes, please provide details:

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7. Liver, kidney, pancreas, gall bladder, or endocrine disorders including but not limited to: pituitary, thyroid, or metabolic disorders, or obesity? Yes No

If yes, please provide details:

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8. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?
Yes No

If yes, please provide details:

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9. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis, or inflammation? Yes No

If yes, please provide details:

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10. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, and/or disorders of the reproductive system or of menstruation, including but not limited to: vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus, and hormone replacement therapy? Yes No N/A

If yes, please provide details:

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11. Digestive system, stomach, colon, rectum, or intestines, including but not limited to: esophageal regurgitation, gastritis, ulcers, Crohn's Disease, and/or diverticulitis? Yes No

If yes, please provide details:

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12. Any other disease, medical problem, illness, injury, or condition of any kind not listed above? Yes No

If yes, please provide details:

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13. Do you take any specialty prescriptions or any prescription not already indicated in the above questions? Yes No

If yes, please provide details:

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Signature: ____________________________________ Date: _________________________