STRATEGIC OUTSOURCING SOLUTIONS

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 hosptialized 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.**

group benefit plans. By signing this form you consent to such use, and your consent will remain effective unless and until revoked. Signing this form does not enroll you in an SOS benefit plan, nor is it a condition of treatment, payment, enrollment, or eligibility under SOS benefit plans. SOS's Notice of Privacy Practices provides more detailed information about how your protected health information may be used by SOS under privacy laws, and you consent to such uses. You have the right to review the Notice of Privacy Practices before signing this form. SOS will treat your information in accordance with this consent and the Notice of Privacy Practices, but once your information has been disclosed to others it may no longer be protected by privacy laws. You may revoke your consent at any time; revocation will be effective as of the date received in writing by the SOS benefits department and will not apply to information that has already been used or disclosed in reliance on your previous consent. SOS will provide you a copy of this form as signed by you on your written request.

By signing below you certify that: you have given your consent voluntarily; you understand that SOS and its insurers and actuaries will rely on the information you provide; and the information you provide on this form is true and complete to the best of your knowledge (however, persons employed in Michigan should omit information about height and weight). You also agree to immediately notify SOS in writing of any changes to the information you provide on this form that you become aware of between your submission of this form and the date upon which you become covered by any SOS benefit plan. If you knowingly make any misrepresentations or omissions on this form, or in updating or failing to update the information on this form, it could result in denial of claims, changes in coverage terms and premium, and/or cancellation or rescission of all coverage under SOS benefit plans.

Employee SIGN HERE and Date:

➡_____ Date:_____