Aetna Texas Small Group Prescreen Questionnaire

Employer Name ____

Employee Name ____

A. Employee Information – Must be completed by employee.

Home Address

Street ______________________ City ______________________ State ________ Zip Code ____________

B. Individuals Covered - *List individuals for whom you are enrolling.*

		Name (Last, First, M.I.)	Height/ Weight	Sex M/F	Social Security Number
Employee	**1.**				
Spouse	**2.**				
Child	**3.**				
Child	**4.**				

C. Health Questionnaire

Health History for Individuals and Their Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you and your dependents.

In the past five (5) years, have you, your spouse or any of your dependents: **Yes** **No**

1. Had, consulted for, had treatment rendered, been advised to have treatment or been hospitalized for any of the following: Cardiovascular disease or heart attack; high blood pressure, stroke; disorder of the kidneys, stomach, intestines or liver; hepatitis; musculoskeletal conditions; mental or nervous condition; central nervous system disorder; transplant; diabetes; any disorder of the lungs or respiratory system; or cancer? ☐ ☐
2. Has any person to be covered had or been told they have an immune disorder, AIDS or AIDS-Related Complex by a physician/medical doctor? ☐ ☐
3. Have you or any dependents to be covered visited a healthcare professional for any illness and/or medical condition resulting in medical expenses more than $5,000 in the past 24 months? ☐ ☐
4. Have you or any dependent to be covered been advised in the last 12 months that hospitalization, surgery or treatment needed or pending? ☐ ☐
5. a. Is any female to be covered currently pregnant? ☐ ☐
   b. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form? ☐ ☐
6. Does anyone listed on this enrollment form use tobacco products, including cigarettes, pipe, cigar, or chewing tobacco? ☐ ☐
7. Has any applicant taken any prescribed medications in the past 6 months? **If Yes, list below**. ☐ ☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE YOU MUST COMPLETE SECTION D.

D Health Questionnaire - Details for "Yes" Responses in Section C

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION C, YOU MUST COMPLETE THE FOLLOWING.
Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Section C. **In addition**, please give details below of last doctor visit and/or physical examination for **ALL** family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Under Treatment
							☐ Yes ☐ No

Treatment Given

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Under Treatment
							☐ Yes ☐ No

Treatment Given

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Under Treatment
							☐ Yes ☐ No

Treatment Given