



MEDICAL RISK QUESTIONNAIRE

ENROLLED IN PLAN YES ___ NO ___

Patient Name: _____ SSN: _____ Birthdate: _____

Male ___ Female ___ Home Phone: _____ Daytime Phone: _____

Address: _____ Cell Phone: _____

Policy Holder Name: _____ SSN: _____ Birthdate: _____

| | |
|-----------------|---------------|
| List Dependents | Relationship: |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Has a doctor ever told you that you have (check all that apply) **HEALTH INFORMATION IS KEPT CONFIDENTIAL**

___ Asthma ___ Coronary heart disease ___ Diabetes ___ High cholesterol ___ Hypertension

Other medical problems: _____

Past Surgeries: _____

Current prescription or over the counter medications: _____

Allergies: ___ Yes ___ No Type: _____ Special diet: ___ Yes ___ No Type _____

Height: _____ Weight: _____ Do you drink alcohol? ___ Yes ___ No (daily, weekly, not often, never)

Do you use tobacco? ___ Yes ___ No Type: _____ Amount: _____

Do you exercise? ___ Yes ___ No Type: _____ How often: _____

Last blood pressure reading: _____ Last blood sugar level: _____ Last cholesterol level: _____

Date of last: Colonoscopy _____ PSA test _____

Pap smear _____ Clinical breast exam _____ Mammogram _____

**Return to: IMA, Inc.
318-747-5074 - fax**