

McMullen Insurance - Health Prescreen Form

Please fill out this form so we can accurately give you a quote on Health Insurance. Please fax to 775-738-0637

Name _____ Date of Birth ____/____/____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Male Female Smoke Yes No Do you have health insurance Yes No Company _____

Have you been under the care of a medical doctor during the past two years? YES NO

If YES, what for? _____

Physician's Name _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

In case of emergency please contact (closest friend or relative) Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Have you been treated in a hospital in the last five years? YES NO

Have you taken any medication or drugs during the past two years? YES NO

Are you taking any medication, drugs or pills now? YES NO

If yes, please list name and dosage: _____

Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES NO

If YES, please list: _____

The pharmacy/pharmacist I use is: _____

I consider myself to be in good health: YES NO Comments: _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	YES	NO	Ulcers	YES	NO
Hepatitis A (infectious) B (serum)	YES	NO	Chest Pain	YES	NO
Diabetes	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Thyroid Problems	YES	NO
AIDS	YES	NO	Heart Murmur	YES	NO
Glaucoma	YES	NO	HIV Positive	YES	NO
High Blood Pressure	YES	NO	Contact Lenses	YES	NO
Cold Sores/Fever Blisters	YES	NO	Mitral Valve Prolapse	YES	NO
Emphysema	YES	NO	Blood Transfusion	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO
Hemophilia	YES	NO	Heart Pacemaker	YES	NO
Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO
Bruise Easily	YES	NO	Arthritis/Rheumatism	YES	NO
Hay Fever	YES	NO	Liver Disease	YES	NO
Cortisone Medicine	YES	NO	Latex Sensitivity	YES	NO
Yellow Jaundice	YES	NO	Swollen Ankles	YES	NO
Allergies or Hives	YES	NO	Neurological Disorders	YES	NO
Stroke	YES	NO	Sinus Trouble	YES	NO
Epilepsy or Seizures	YES	NO	Diet (Special/Restricted)	YES	NO
Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Artificial Joints(hip, knee, etc)	YES	NO	Chemotherapy	YES	NO
Nervous/Anxious	YES	NO	Kidney Trouble	YES	NO
Tumors	YES	NO	Psychiatric/Psychological Care	YES	NO

Have you lost or gained more than 10 pounds in the past year? YES NO

Do you have or have you had any disease, condition or problem not listed? YES NO

If YES, please list: _____

WOMEN: Are you: Pregnant? Yes, _____ months No Nursing? YES NO Taking birth control pills? YES NO