BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

# Medical Questionnaire - Diagnosis Detail

**Name of Employee:** _____ **Soc. Sec. No.:** _____

**Instructions:** Answer ALL of the questions (front and back of form) concerning the medical conditions of the following person:_____**(name of the person with condition).**

This form may be completed by the employee, a legal guardian, a spouse or agent. Medical records may possibly be required.
**Please use extra sheets if additional space is needed. Be sure to include the question number with each response.**
*(Please state "none" if not applicable)*

1. Age of Person with condition: _____ Consume Alcohol: [ ]Yes: per day amount: _____ [ ] No
   Height/Weight of Person with condition: _____/_____ Used Tobacco products within last 12 months? [ ]Yes [ ]No

2. What is the condition and what date was it diagnosed (if Hepatitis, please indicate which type)? _____
   _____
   _____

3. How is/was this condition treated? (Include dates, frequency of visits to medical provider, all hospitalizations, therapy, and prior or planned surgeries): _____
   _____

4. What prescription drugs are currently being taken or have been taken in the past for this condition? (Include dates and the amount of the medication taken): _____
   _____
   _____

5. Do any of the following symptoms or diagnosis exist?

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Chest Pain | ☐ | Heart Problems | ☐ | Jaundice |
| ☐ | Abdominal pain | ☐ | Digestive Problems | ☐ | Leg Ulcers |
| ☐ | Congestive Health Failure | ☐ | Nasal Congestion/bleeding | ☐ | Paralysis |
| ☐ | Abnormal menstrual cycles | ☐ | Renal Insufficiency | ☐ | Hepatitis B, C, or E |
| ☐ | Hearing/Sensory Loss | ☐ | Neurological condition/Stroke | ☐ | Joint Pain |
| ☐ | Frequent fevers or Infections | ☐ | Hematuria (blood in urine) | ☐ | Cysts |
| ☐ | Bladder spasms or problems | ☐ | Easily tired or fatigued | ☐ | Infertility |
| ☐ | Bone or Bone Marrow Disease | ☐ | Speech difficulty | ☐ | Joint Replacement |

Other symptoms: _____
_____

6. What is the prognosis of the illness, including the likelihood of any future treatments or surgeries? Have there been any recommendations for treatments? _____
   _____
   _____

7. Are there any physical restrictions or complications as a result of the condition? If so, please explain the use of any assistance devices (i.e. cane, wheelchair, oxygen):_____
   _____
   _____

8. How often is there follow up with a physician regarding the condition (including routine lab work)? When was the last time a physician was seen regarding your condition? _____
   _____

9. If **epilepsy** or **seizure** condition, how frequently do the seizures occur? When was the last seizure?
   _____

**----------COMPLETE BOTH SIDES OF THIS FORM ----------**

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10. Is the person a **Diabetic**? [ ] Yes [ ] No

If yes, complete this section:

| | Date | Results | Check if Unknown |
|---|---|---|---|
| a. Most recent Glycohemoglobin A1C | _____ | _____ | [ ] |

b. Last 3 Blood Sugar Readings:

| Taken in Doctor's Office | | Date | Blood Sugar Reading | Check if Unknown |
|---|---|---|---|---|
| [ ] Yes | [ ] No | 1._____ | _____ | [ ] |
| [ ] Yes | [ ] No | 2._____ | _____ | [ ] |
| [ ] Yes | [ ] No | 3._____ | _____ | [ ] |

Has there been an eye disorder diagnosis? If yes, please explain, including diagnosis, date of diagnosis, and treatment:

_____

_____

Do any of the following exist: High Blood Pressure (if yes, provide last blood pressure reading), Kidney disease, heart condition, numbness/pain to hands or feet (neuropathy)? If yes, please explain, including current medications/treatment:

_____

_____

11. Answer the following if **Breast Cancer or Melanoma has existed within the past 10 years OR any other Cancer within the past 5 years – including Leukemia, Lymphoma, Hodgkin's, Malignant Cysts or Cervical Dysplasia:**

| Type of Cancer | Date Diagnosed | Parts of body affected | Lymph Node Involvement? | Chemotherapy or Radiation Start Date | Completed |
|---|---|---|---|---|---|
| _____ | ___/____/_____ | _____ | [ ]Yes [ ]No | _____ | - _____ |
| _____ | ___/____/_____ | _____ | [ ]Yes [ ]No | _____ | - _____ |
| _____ | ___/____/_____ | _____ | [ ]Yes [ ]No | _____ | - _____ |

Provide details as to the current status, any recurrence of the condition and future treatment recommended:

_____

_____

If Cervical Dysplasia: the type cell found _____, the grade of Sequamous cell _____, and dates of last ***normal*** pap smears (1)_____(2)_____

12. Answer the following if an **Organ or Bone Marrow Transplant** has either occurred or is being awaited:

a. Primary Diagnosis (reason for and type of transplant) _____

_____

b. How is/was the condition treated (surgery, hospitalizations, etc.)? _____

_____

c. Has there ever been a rejection, limitations, or current symptoms due to a previous transplant? If yes, explain.

_____

_____

13. Answer the following for **Premature Infants (born at 37 gestational weeks or less) currently less than 24 months of age:** Number of gestational weeks when born _____ Date of birth _____

List any birth complications and/or medical problems associated with the premature birth, including RSV treatment such as Synergis injections (give dates)_____

_____

**It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

Completed by (Print Name):_____Relationship to person with condition:_____

Signature: _____ Date: _____