



## PPO Pre-Existing Conditions Questionnaire

1. Have you or your dependent(s) been diagnosed as having a pre-existing condition in the last six months  Yes  No

If you answered yes, please check all the answers that apply then continue to question 2. If you answered no, please continue to question 2.  
After completing questions 1 and 2, please sign and date the form and provide your Social Security Number.

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| <ul style="list-style-type: none"> <li>a. Addison's Disease <input type="checkbox"/></li> <li>b. Amyotrophic Lateral Sclerosis (ALS) <input type="checkbox"/></li> <li>c. Ankylosis Spondylitis <input type="checkbox"/></li> <li>d. Aortic Aneurysm <input type="checkbox"/></li> <li>e. Asbestosis <input type="checkbox"/></li> <li>f. Asthma <input type="checkbox"/></li> <li>g. Behcet's Disease <input type="checkbox"/></li> <li>h. Bronchiectasis <input type="checkbox"/></li> <li>i. Cancer (all types) <input type="checkbox"/></li> <li>j. Cerebral Palsy <input type="checkbox"/></li> <li>k. Cerebral Vascular Accident (stroke) <input type="checkbox"/></li> <li>l. Cholelithiasis (Gall Bladder Disease) <input type="checkbox"/></li> <li>m. Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/></li> <li>n. Chronic Pain <input type="checkbox"/></li> <li>o. Crohn's Disease <input type="checkbox"/></li> <li>p. Cirrhosis of Liver <input type="checkbox"/></li> <li>q. Congestive Heart Failure (CHF) <input type="checkbox"/></li> <li>r. Coronary Artery Disease (CAD) <input type="checkbox"/></li> <li>s. Cystic Fibrosis <input type="checkbox"/></li> <li>t. Deep Vein Thrombosis (DVT) <input type="checkbox"/></li> <li>u. Depression <input type="checkbox"/></li> <li>v. Dermatomyositis / Polymyositis <input type="checkbox"/></li> <li>w. Diabetes Mellitus <input type="checkbox"/></li> <li>x. Emphysema <input type="checkbox"/></li> <li>y. End State Renal Disease (ESRD) <input type="checkbox"/></li> <li>z. Gaucher <input type="checkbox"/></li> <li>aa. Hemophilia <input type="checkbox"/></li> <li>bb. Hepatitis <input type="checkbox"/></li> <li>cc. Herniated Disk <input type="checkbox"/></li> <li>dd. HIV/AIDS <input type="checkbox"/></li> <li>ee. Leukemia <input type="checkbox"/></li> <li>ff. Lupus <input type="checkbox"/></li> <li>gg. Lymphoma <input type="checkbox"/></li> <li>hh. Meckel's Diverticulum <input type="checkbox"/></li> </ul> | <ul style="list-style-type: none"> <li>ii. Mental Health Disorders <input type="checkbox"/></li> <li>jj. Mixed Connective Tissue Disease (MCTD) <input type="checkbox"/></li> <li>kk. Multiple Sclerosis <input type="checkbox"/></li> <li>ll. Muscular Dystrophy <input type="checkbox"/></li> <li>mm. Myesthenia Gravis <input type="checkbox"/></li> <li>nn. Myocardial Infarction (heart attack) <input type="checkbox"/></li> <li>oo. Nephritis <input type="checkbox"/></li> <li>pp. Obesity, Morbid <input type="checkbox"/></li> <li>qq. Osteomyelitis <input type="checkbox"/></li> <li>rr. Paget's Disease <input type="checkbox"/></li> <li>ss. Pancreatitis <input type="checkbox"/></li> <li>tt. Parkinson's <input type="checkbox"/></li> <li>uu. Peripheral Vascular Disease <input type="checkbox"/></li> <li>vv. Pernicious Anemia <input type="checkbox"/></li> <li>ww. Pituitary Adenoma <input type="checkbox"/></li> <li>xx. PKU <input type="checkbox"/></li> <li>yy. Pulmonary Embolism <input type="checkbox"/></li> <li>zz. Radiculopathy <input type="checkbox"/></li> <li>aaa. Renal Artery Stenosis <input type="checkbox"/></li> <li>bbb. Rheumatoid Arthritis <input type="checkbox"/></li> <li>ccc. Sarcoidosis <input type="checkbox"/></li> <li>ddd. Scleroderma <input type="checkbox"/></li> <li>eee. Seizure Disorder <input type="checkbox"/></li> <li>fff. Short Stature with use of growth hormone <input type="checkbox"/></li> <li>ggg. Sickle Cell <input type="checkbox"/></li> <li>hhh. Sjogrens Syndrome <input type="checkbox"/></li> <li>iii. Substance Abuse (including alcohol) <input type="checkbox"/></li> <li>jjj. Surgical procedures (elective) scheduled prior to enrollment <input type="checkbox"/></li> <li>kkk. Thyroid Disorder <input type="checkbox"/></li> <li>lll. Transient Ischemic Attack (TIA) <input type="checkbox"/></li> <li>mmm. Tuberculosis (TB) <input type="checkbox"/></li> <li>nnn. Ulcer <input type="checkbox"/></li> <li>ooo. Ulcerative Colitis <input type="checkbox"/></li> </ul> |
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2. During the last six months, have you or any dependent to be covered:

- a. been examined or treated by a physician or other health care provider for any condition, illness or injury other than as stated above?  Yes  No
- b. been advised to have treatment, surgery or testing that has not been done?  Yes  No
- c. been admitted to a hospital or other health care facility as an inpatient?  Yes  No
- d. taken prescribed medications?  Yes  No

Please give details for any "Yes" to questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question # and letter	Name of Person	Relationship to Subscriber	Condition	Duration of Symptoms, Treatment, Degree of Recovery	Date	Name & Address of Hospitals, Practitioners

Date: \_\_\_\_\_

Signature of Subscriber: \_\_\_\_\_ Subscriber's Social Security Number: \_\_\_\_\_