ADD – Attention Deficit Disorder
ADHD – Attention Deficit Disorder with Hyperactivity
Medical Questionnaire

Applicant Name:_____ **Applicant ID Number:**_____

Please answer all questions thoroughly. Omissions or incomplete responses could result in a request for medical records and a delay in processing of this application. Use separate sheet of paper if necessary.

1. What is your specific diagnosis & when were you diagnosed?_____
_____

2. Have you ever been treated for depression, anxiety, panic disorder, obsessive-compulsive disorder, any type of eating disorder, drug or alcohol abuse or any other behavioral health condition?
☐**YES** ☐**NO** If YES, please circle the condition(s) and provide explanation.

_____
_____
_____

3. Have you been hospitalized, institutionalized, or been evaluated in an emergency room or urgent care facility for this condition? ☐**YES** ☐**NO** If YES, please provide the following information.

DATE OF VISIT	PHYSICIAN or FACILITY NAME	ADDRESS	TYPE OF TREATMENT
mo/yr _____			
mo/yr _____			

4. Please list all medications taken for this condition in the space provided.

MEDICATION NAME	DOSAGE & FREQUENCY	DATE PRESCRIBED	DATE DISCONTINUED	PRESCRIBING PHYSICIAN
		mo/yr _____	mo/yr _____	
		mo/yr _____	mo/yr _____	
		mo/yr _____	mo/yr _____	

5. How many Physician and/or Counseling visits have you had for this condition in the past 12 months?
Please complete below. . Use separate sheet of paper if necessary.

DATE OF VISIT	PHYSICIAN/ COUNSELOR'S NAME	ADDRESS	TYPE OF TREATMENT
mo/yr _____			
mo/yr _____			
mo/yr _____			

6. Has any other treatment been recommended for this condition but not yet completed?
☐**YES** ☐**NO** If YES, please explain._____
_____
_____

Signature:_____**Date:**_____
Applicant or Parent/Guardian

Underwriting Department
Health Net of Arizona, Inc.
1230 W. Washington Street, Suite 401, Tempe, Arizona 85281
For assistance, please call 1-888-463-4875, Option 2