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**Supplement to SOLO® Application**  
**GENERAL HEALTH QUESTIONNAIRE**

1. Name of Primary Applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_.
2. Patient Name: \_\_\_\_\_.
3. Name of person filling out this form: \_\_\_\_\_.
4. When was the patient's last physical examination (mm/yyyy)? \_\_\_\_\_. What concerns, findings, symptoms, diagnosis, or referrals were made during that examination or any other visit with you?(please provide details).  
\_\_\_\_\_.
5. Who was the physician that performed this exam(name, address and phone number)?  
\_\_\_\_\_.
6. Current Height in office (Feet/Inches): \_\_\_\_\_.
7. Current Weight in office (Pounds), with or without shoes? \_\_\_\_\_.
8. Hip Circumference (in centimeters): \_\_\_\_\_.
9. Waist Circumference (in centimeters): \_\_\_\_\_.
10. Review of Systems:  
\_\_\_\_\_  
\_\_\_\_\_.
11. Appearance: Normal: \_\_\_\_\_. Overweight: \_\_\_\_\_. Obese: \_\_\_\_\_.
12. Blood Pressure in Office: \_\_\_\_\_.
13. List all medications this patient has taken in the past 5 years whether over-the-counter or prescription and primary purpose of which he/she was taking them:  
\_\_\_\_\_  
\_\_\_\_\_.
14. Has this patient been experiencing **any** symptoms (including, for example: snoring, night sweats, rashes, shortness of breath, dizziness, chest tightness, vision problems, etc.) that he/she has not had checked by a physician? Yes or No: \_\_\_\_\_. If yes, please explain these symptoms in detail.  
\_\_\_\_\_  
\_\_\_\_\_.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my patient's application for consideration of coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Physician Signature: \_\_\_\_\_.  
Today's Date: \_\_\_\_\_.

3/1/2007