



**Viva Health Inc. Health Questionnaire—  
Follow up: Colitis**

Employee Name: \_\_\_\_\_ Group Name: \_\_\_\_\_  
Proposed Insured: \_\_\_\_\_ D.O.B. \_\_\_\_\_

1. Have you ever been diagnosed with one of the following? (please circle)  
Functional Colitis   Ulcerative Colitis   Spastic Colon   Crohn's Disease   Dysentery  
Give the dates of diagnosis.
2. Give the name and address of your physician.
3. What symptoms were you experiencing when the initial diagnosis was made?
4. When did you last experience these symptoms?
5. How often do you have these symptoms?
6. What effect do these symptoms have on your activities of daily life ) e.g. work, caring for family, etc.)?
7. Have you ever been hospitalized for this condition? Yes/No *If yes, please give dates and length of stay.*
8. What medications have been prescribed for you for this condition? Please include current medication along with dosage and frequency.
9. Have you had any tests run for this condition? Please list all tests, including dates and results.
10. Has surgery ever been mentioned or have you ever had surgery for this condition?  
*Yes/No If yes, please give details of type of surgery and date.*
11. Has your doctor prescribed a diet for you to control the frequency or severity of symptoms of colitis? Yes/ No  
How often do you follow the diet? Always   Most of the time   Sometimes   Seldom
12. Do you smoke? *If yes, how many cigarettes per day?*

**I represent to the best of my knowledge and belief that each of the above statements and answers are complete and true. I understand that the answers to the above questions will be the basis of any coverage issued ant that any incorrect answers may operate to void this insurance.**

**Date:** \_\_\_\_\_ **Signature of proposed insured:** \_\_\_\_\_

Use reverse side for additional comments or if further space is needed.