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Supplement to ConnectiCare® SOLO Application
RESPIRATORY QUESTIONNAIRE

Name of primary applicant: _____ ID/SSN: _____.

Name of person related to condition: _____.

1. Please check all that apply to you:

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Deviated septum | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumothorax |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Other: _____ | |

2. Date of diagnosis? _____ Date of last symptom: _____.

3. Check all that apply to you:

- Frequent wheezing Wheezing when talking Wheezing when resting

4. Please indicate all medications you are taking, their names, dosages, and the frequency with which you are taking them (if supplemental oxygen use or Nebulizer or allergy shots please indicate):

5. How many attacks have you had per year? _____. When was the date of your last attack?
_____. Has surgery been recommended to correct this condition? Yes or No: _____.

6. Have you had an asthma attack requiring doctor's visit, hospitalization(s) or emergency room visits for this condition? Yes No If yes, provide details to the following:

- Reason for seeking treatment or confinement? _____
- Date(s) of confinement/visits: _____
- Number of visits/confinements: _____
- Name and address of doctor/hospital where seen:

7. Any work loss or restricted activities? Yes or No: _____. If yes, please explain:

8. Please check all that apply and indicate results here: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergy-testing | <input type="checkbox"/> X-ray studies | <input type="checkbox"/> Specialist's exam |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Pulmonary function test | <input type="checkbox"/> Other: _____ |

9. How often do you see the doctor for this condition? _____. Please provide his/her name and address:

10. Are you currently using tobacco products? Yes or No: _____. If yes, how much/how often do you use them? _____. If no, when did you quit? _____.

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 applicant for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent / guardian if under 18) below: _____.

Today's Date: _____.