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3 Are you male or female?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
670	Other	3 0	Y	F					FLG	00	E_MAMMO	
											FLAGAPP	
											FLAGDKTR	1 Please complete the attached mammogram form, required of all female applicants over the age of 40.

8 Weight in pounds

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
2	Endocrinology	8 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * stated weight equal or lower than a BMI of 19 - see attached special form.
											FORM-UNDER	
1	Endocrinology	8 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * stated weight is equal or greater than BMI of 29 - see attached special form. Peace Corps is unable to reimburse for this evaluation.
											FORM-OVER	

10 Do you smoke cigarettes or use tobacco products?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
49	Pulmonary	10 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	1 * smokes cigarettes or uses tobacco products
											FORM-SMOKE	

11 Do you currently wear dental braces? (This does NOT include removable orthodontic retainers, dentures, partial plates, or bridges.)

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Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
50	Dental Exam	11 0	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthodontist. 2 *Condition reported: Currently wears dental braces - Your current status - Requirements for follow up over the next three years - Whether or not you wear a retainer
											FLAGAPP	
											FLAGDKTR	1 * You reported that you are currently wearing dental braces. As Peace Corps cannot provide orthodontic support overseas, we must defer final action on your application until the braces are removed and all follow-up visits are finished. Use of a removable retainer can be accommodated. After completion of your orthodontic course of treatment, we will need documentation from your orthodontist. Please see the enclosed evaluation form.

 # 12 Have you ever had:

(*1*) *Multiple inner ear infections after age 15*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
52	Ear, Nose, and Throat	12 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Inner ear infections (chronic otitis media) since age 15. -Diagnosis:

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1 Multiple inner ear infections after age 15

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Date of diagnosis: -Dates of all infections to include last infection: -Symptoms: -Severity: -Date symptoms resolved: -Aggravating or precipitating factors: -Treatment: -Medications: -Procedures (e.g. myringotomy) -Current status: -Restrictions, incl. flight restrictions if applicable: -Specific recommendations for follow-up over the next three years -Attach: -results of audiogram if history of hearing loss. Note any progression. -copy of related surgical/procedure reports, if applicable.

(*2*) *Meniere's disease*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
64	Ear, Nose, and Throat	12 2	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Meniere's Disease. -Diagnosis: -Date of diagnosis:

2 Meniere's disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Symptoms: -Severity of symptoms: -Frequency of symptoms: -Date symptoms resolved: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status -Specific requirements for follow up for the next 3 years: -Attach: -discharge summary, if surgical procedure was performed -results of current audiogram if history of hearing loss. Note any progression.

 # 13 Do you currently require the use of at least one hearing aid?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
630	Ear, Nose, and Throat	13 0	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an audiologist 2 * Condition reported: Using hearing aid(s) in one or both ears - Diagnosis:

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Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	- Etiology of hearing loss: - Type of Hearing loss: - Is the hearing loss stable or progressive: - Onset: - Type and model number of present hearing aids - Date purchased: - Expected longevity: - Date of last check/overhaul: - Likelihood of needing a new hearing aid in next 3 years - Describe care of hearing aids (ie: are they affected by climate) Audiologist: Please instruct the applicant in routine cleaning and maintenace of the hearing aid. Attach a copy of an audiogram done within one year (both aided and unaided) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Currently using hearing aid(s) - evaluation by a audiologist has been requested

 # 14 Within the last 5 years, other than tonsillectomy, childhood tonsillitis or wisdom teeth extraction, have you had any condition or have you had any surgery on your ears, nose, face, sinuses, jaw, or throat not listed in items 11-13?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text

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Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
65	Ear, Nose, and Throat	14 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Unspecified condition or surgery on your ears, nose, face, sinuses, jaw or throat -Diagnosis: -Date of diagnosis: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment: -Type of surgery: - Date(s) of surgery: -Current status: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: -copy of hospital discharge summary and/or surgical report. -copy of all pertinent diagnostic test reports

 # 15 Do you have or have you ever had:

(*1*) *Glaucoma*

Rule #	Group	Timeframe	Mod

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1 Glaucoma

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
67	Ophthalmology	15 1	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an ophthalmology specialist (MD). 2 * Glaucoma -Specify type: -Date of onset of symptoms: -Current intraocular pressure (O.U.): -Treatment (incl. medications, any surgical procedures, and dates initiated/performed): -Current medications: -Limitations or restrictions: -Specific requirement for follow-up over next three years: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * glaucoma - evaluation by a specialist has been requested

(*2*) *Herpes infection of the cornea (herpes keratitis)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
68	Ophthalmology	15 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an ophthalmology specialist. 2 * A Herpes infection of the cornea. -Onset

2 Herpes infection of the cornea (herpes keratitis)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Number of episodes: -Treatment -Date resolved -Current status -Likelihood of recurrence or exacerbation -Specific recommendations for follow-up over the next three years Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Herpes keratitis - evaluation by an ophthalmology specialist is requested.

(*3*) *Optic neuritis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
72	Ophthalmology	15 3	Y					12	FLG	00	EVALFORM 1	This evaluation must be completed by an ophthalmology specialist (MD).
											2	* Optic Neuritis Date of initial episode: Number of episodes: Date of last episode: Etiology:

3 Optic neuritis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Likelihood of recurrence or exacerbation: Specific requirement for follow-up over next three years: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* optic neuritis - evaluation by a specialist has been requested.

(*4*) *Chronic uveitis or iritis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
76	Ophthalmology	15 4	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an ophthalmologist. 2 * Condition reported: chronic Uveitis or Iritis -Diagnosis: -Date of initial episode: -Number of episodes: -Date of last episode: -Etiology: -Likelihood of recurrence or exacerbation: -Specific requirement for follow-up over next three years:

4 Chronic uveitis or iritis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding chronic uveitis or iritis.

(*5*) *Cataract surgery*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
77	Ophthalmology	15 5	Y						FLG	00	EVALFORM 1	This evaluation must be completed by an ophthalmology specialist (MD).
											2	* Condition reported: Cataract surgery -Name(s) of surgical procedure(s)- indicate if O.S. or O.D. -Date(s) of all surgeries: -Current visual acuity -O.S.: -O.D.: -Specific requirement for follow-up over next three years (incl. need for additional surgery): - Include surgery report (if less then one year post op)

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5 Cataract surgery

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* cataract surgery - evaluation by a specialist has been requested

(6) Other vision correcting surgery, such as RK, PRK, LASIK

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
78	Ophthalmology	15 6	Y						FLG	00	EVALFORM 1	This evaluation must be completed by an ophthalmology specialist (MD).
											2	* Condition reported: vision correcting surgery such as RK, PRK LASIK -Specific type of surgery(-ies): -Date of surgery (-ies): -Current visual acuity: -O.D.: -O.S.: -Complications: -Date released from further follow-up: -Specific requirement for follow-up over next three years: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?

6 Other vision correcting surgery, such as RK, PRK, LASIK

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGAPP	
											FLAGDKTR	1 * vision correcting surgery such as RK, PRK, LASIK - evaluation by a specialist has been requested

(7) Macular or lattice degeneration (degeneration of the retina)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
79	Ophthalmology	15 7	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an ophthalmology specialist (MD). 2 * Condition reported: Degeneration of the retina (macular or lattice degeneration) -Diagnosis: -Date of onset: -Etiology (specify lattice/macular - if macular must specify exudative or non exudative): -Location (right, left or both): -Symptoms: -Frequency of symptoms: -Severity: -Treatment (corrective lenses, exercises etc) with dates initiated and completed: - Associated complications: -Current medication(s): -Limitations or restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this

7 Macular or lattice degeneration (degeneration of the retina)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	condition in the last 12 months: -Specific requirement for follow-up over next three years: - Submit related surgery reports or statement from treating provider describing procedure and resolution (if applicable). Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	*Degeneration of the retina (macular or lattice degeneration) - an evaluation by a specialist has been requested.

(*8*) *Retinal detachment*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
80	Ophthalmology	15 8	Y						FLG	00	EVALFORM 1	This evaluation must be completed by an ophthalmology specialist (MD).
											2	* Condition reported: Retinal Detachment -Number of episodes: -Date of last episode: -Etiology: -Treatment (include specific procedure and date performed): -Likelihood of recurrence or exacerbation:

8 Retinal detachment

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Specific requirement for follow-up over next three years: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding retinal detatchment.

 # 16 Within the last 5 years, other than astigmatism or use of corrective lenses, have you had any other condition or surgery of the eye not listed in Item 15?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
82	Ophthalmology	16 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Unspecified eye condition, injury or surgery other than astigmatism or use of corrective lenses -Diagnosis: -Date of diagnosis: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment: -Current status:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Visual acuity: -O.D.: -O.S.: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirement for follow-up over next three years: Attach: copies of all pertinent diagnostic test reports

 # 17 Are you allergic to:

(*1*) *Sulfa drugs (such as Bactrim, Septra)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
85	Allergy	17 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * An allergy to sulfa drugs This is not a request either for allergy testing or that you go to an allergist. -Description of reaction: -Severity of reaction: -Date of last reaction: -Treatment required to resolve symptoms (attach copy of ER/hospital discharge summary if applicable):

(*2*) *Other medication(s)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
84	Allergy	17 2	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2

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2 Other medication(s)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	* An allergy to medication(s) other than sulfa drugs This is not a request either for allergy testing or that you go to an allergist. -Medication(s) to which allergic: -Description of reaction: -Severity of reaction: -Date of last reaction: -Treatment required to resolve symptoms -Attach: copy of ER/hospital discharge summary if applicable):

(*3*) *Eggs*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
633	Allergy	17 3	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a primary care provider or allergist. 2 * An allergy to Eggs Please note: Egg-based vaccines are required for Peace Corps service Documentation of Egg Allergy -Description of reaction: -Severity of reaction: -Date of last reaction: -Treatment of reaction: -If can safely be given administer the following vaccines: Vaccines Date Given Reaction noted Influenza _____

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3 Eggs

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	_____ Yellow Fever (if > 7 years since last) _____ _____ Physician Name:_____ Date:_____ Physician Signature:_____ Physician Lic.#_____ Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Condition Reported: Egg Allergy - An evaluation by a primary care provider or allergist has been requested

(*4*) *Peanuts*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
634	Allergy	17 4	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* An allergy to Peanuts This is not a request either for allergy testing or that you go to an allergist. -Diagnosis: -Allergen: -Description of reaction:

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4 Peanuts

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Severity of reaction: -Date of last reaction: -Treatment required to resolve symptoms (attach copy of ER/hospital discharge summary if applicable): -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow up for the next 3 years:

(*5*) *Shellfish*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
635	Allergy	17 5	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * An allergy to Shellfish This is not a request either for allergy testing or that you go to an allergist. -Diagnosis: -Allergen: -Description of reaction: -Severity of reaction: -Date of last reaction: -Treatment required to resolve symptoms (attach copy of ER/hospital discharge summary if applicable):

5 Shellfish

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow up for the next 3 years:

(6) Other food(s)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
86	Allergy	17 6	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * An allergy to food(s) This is not a request either for allergy testing or that you go to an allergist. -Food(s) to which allergic: -Description of reaction: -Severity of reaction: -Date of last reaction: -Treatment required to resolve symptoms (attach copy of ER/hospital discharge summary if applicable): -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow up for the next 3 years:

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(7) *Bee, wasp or other insect stings*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
87	Allergy	17 7	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Bee, Wasp or Other insect sting allergies This is not a request either for allergy testing or that you go to an allergist. -Allergen(s): -Description of reaction: -Severity of reaction: -Date of last reaction: -Treatment required to resolve symptoms (attach copy of ER/hospital discharge summary if applicable): -Is an Epi-pen recommended? YES NO (circle one)

(8) *Environmental allergies (such as grass, pollen, dust animal hair, etc.)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
88	Allergy	17 8	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Environmental allergies This is not a request either for allergy testing or that you go to an allergist. -Allergen(s): -Description of reaction: -Severity of reaction: -Date of last reaction: -Limitations:

8 Environmental allergies (such as grass, pollen, dust animal hair, etc.)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Treatment required to resolve symptoms:

(*9*) *Gluten*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
520	Allergy	17 9	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * An allergy to gluten This is not a request either for allergy testing or that you go to an allergist. -Diagnosis: -Date of diagnosis: -Description of reaction: -Frequency: -Severity: -Date of last reaction: -Treatment history: -Current treatment: -Medications: -Diet: -Limitations/restrictions: Attach: -Current CBC, complete metabolic panel laboratory reports. -Antigliadin AB (AGA), antiendomysial AB (EMA), tissue translutamase (tTG) if available

 # 18 During an allergic reaction, have you ever had:

(*1*) *Difficulty breathing*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
90	Allergy	18 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Difficulty breathing during an allergic reaction -Precipitating allergen, if known: -Description of reaction: -Severity of reaction: -Date of last reaction: -Treatment required to resolve symptoms (attach copy of ER/Hospital discharge summary if applicable): -Prescription for and instructions in use of Epi-pen (emergency allergy kit) given: (CIRCLE ONE) YES NO

(*2*) *Loss of consciousness*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
91	Allergy	18 2	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: lost consciousness during an allergic reaction -Precipitating allergen, if known: -Description of reaction: -Severity of reaction: -Date of last reaction: -Attach copy of ER/Hospital discharge summary if applicable: -Prescription for and instructions in use

2 Loss of consciousness

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	of Epi-pen (emergency allergy kit) given: (CIRCLE ONE) YES NO

(3) Severe swelling of your nose, lips, tongue or throat

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
637	Allergy	18 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: Severe swelling of the nose, lips, tongue or throat during an allergic reaction - Allergens if known - Description of reaction - Severity of reaction - Date of last reaction - Emergency treatment (Attach copy of ER/hospital discharge summary) -Prescription for and instructions in use of Epi-pen (emergency allergy kit) given: (CIRCLE ONE) YES NO

(4) Emergency treatment in a medical facility for an allergic reaction

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
92	Allergy	18 4	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: emergency treatment in a medical facility for an allergic reaction - Allergens: - Description of reaction: - Severity of reaction:

4 Emergency treatment in a medical facility for an allergic reaction

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	- Date of reaction and emergency treatment: - Treatment required to resolve symptoms: - Attach copy of ER/Hospital discharge summary if applicable:

 # 19 Do you have or have you ever had:

(*1*) *Chronic bronchitis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
99	Pulmonary	19 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Chronic bronchitis -Date of onset: -Date of last episode: -Treatment (incl. medications): -Smoking history: -Current status -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirement for follow-up over next three years: -Attach: copy of results of most recent chest x-ray, pulmonary function tests and discharge summary if hospitalized

(*2*) *Emphysema or COPD*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
102	Pulmonary	19 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an internist or pulmonologist (lung specialist). 2 * Condition reported: Emphysema or COPD -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Smoking history: -Limitations or restrictions of Activities of Daily Living: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach copy of results of most recent chest x-ray and results of pulmonary function tests (done within last six months) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?

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2 Emphysema or COPD

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGAPP	
											FLAGDKTR	1 *Emphysema or COPD - an evaluation by a specialist has been requested.

(3) Removal of a lung or a lobe of the lung

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
108	Pulmonary	19 3	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a surgical, pulmonary, thoracic or cancer specialist. 2 * Condition reported: removal of a lung or lobe of lung -Diagnosis: -Date of surgery and procedure performed: -Treatment (incl. medications): -Current status -Smoking history: -Specific requirement for follow-up over next three years: -Attach: copy of results of most recent chest x-ray, pulmonary function tests, pathology report(s) if applicable and discharge summary Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?

3 Removal of a lung or a lobe of the lung

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested for removal of a lung or a lobe of the lung.

 # 20 Since age 15, have you ever:

(1) Experienced wheezing

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
95	Pulmonary	20 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Wheezing after age 15 -See attached special evaluation form
											FORM-AC	

(2) Used an inhaler to prevent breathing problems or to help you breathe

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
96	Pulmonary	20 2	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Use of inhaler for breathing after age 15 -See attached special evaluation form
											FORM-AC	

(3) Been told you have asthma, bronchospasm or reactive(restrictive) airway disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
97	Pulmonary	20 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Asthma, bronchospasm or reactive airway disease, after age 15 -See attached special evaluation form
											FORM-AC	

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21 Within the last 5 years, have you had any respiratory condition, lung condition or surgery not listed in items 19-20?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
113	Pulmonary	21 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Unspecified respiratory or lung condition or surgery -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Date of surgery and procedure performed (if applicable): -Treatment (incl. medications): -Current status: -Smoking history: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirement for follow-up over next three years: -Attach: copy of results of most recent chest x-ray, pulmonary function tests, other pertinent laboratory tests, diagnostic procedure(s) and discharge summary if hospitalized

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22 Do you take prescription medication to control your blood pressure?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
115	Cardiovascular	22 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Take medication to control high blood pressure -Diagnosis: -Date of onset: -Etiology: -Note any Major risk factors, (circle) e.g., smoking, dyslipidemia, diabetes mellitus, age older than 60, family history of cardiovascular disease, women <65, men <55, post-menopausal women: -History of cardiovascular disease (circle), e.g., ventricular hypertrophy, angina, MI, CHF, or coronary revascularization: -History of target organ damage (circle), e.g., stroke, TIA, nephropathy, peripheral vascular disease, or retinopathy: -Treatment: -dietary restrictions: -medications - current dose and date initiated: 1. 2. 3. 4. -lifestyle modification: -Current status: -Three recent consecutive blood pressure readings:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Date_____ BP_____ -Date_____ BP_____ -Date_____ BP_____ -Specific requirement for follow-up over next three years: If treatment includes diuretics: -Copy of current electrolyte results. -Copy of most recent lipid profile results (Cholesterol, HDL, LDL, Triglycerides). If applicable: Discharge summaries of all related hospitalizations.

23 Do you take prescription medication for high cholesterol or high triglycerides?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
116	Cardiovascular	23 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Take prescription medication for high cholesterol/triglycerides -Diagnosis: -Etiology: -Treatment: -Dietary restrictions: -Medications - current dose and date initiated): 1. 2. 3. 4. -Life style modification:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Current status: -Specific requirement for follow-up over next three years: -Attach: - copy of results of most recent lipid profile and liver function studies - dietary management plan (if applicable) - activity/fitness management plan (if applicable) - CPK (if applicable, e.g. treatment includes Isobuteric Acid Derivative or HMG-CoA Reductace Inhibitors)

 # 24 Have you ever had:

(*1*) *Angina*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
118	Cardiovascular	24 1	Y						PND	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist. 2 * Condition reported: angina (angina pectoris) -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history:

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1 Angina

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Current treatment: -Limitations/restrictions: -Altitude restriction required? (CIRCLE ONE) YES NO -If yes, describe restriction in detail (e.g. no altitude greater than 5,000 feet.) -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: - copy of most recent ECG with interpretation - results of stress test, Bruce protocol (if done within last two years) -copies of all other pertinent laboratory and diagnostic test reports Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * angina (angina pectoris)

(*2*) *A heart attack*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
120	Cardiovascular	24 2	Y						PND	00	EVALFORM	1 This evaluation must be completed by a cardiologist or internist. 2 * Condition reported: heart attack

2 A heart attack

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Date of infarction: -Treatment (incl. medications): -Current status: -Limitations or restrictions of ADLs: -Current height/weight: -Blood pressure: -Pulse rate and rhythm: -Smoking history: -Specific requirements for follow-up over next three years: -Attach: - copy of most recent ECG with interpretation - results of stress test done within past twelve months (Bruce protocol; if Bruce protocol inconclusive, a thallium stress test is required) - results of most recent lipid profile. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND 1	* a heart attack

(*3*) *Coronary artery or heart by-pass surgery*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
127	Cardiovascular	24 3	Y						PND	00	EVALFORM 1	This evaluation must be completed by a cardiology specialist or cardiovascular

3 Coronary artery or heart by-pass surgery

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	surgeon. 2 * Condition reported: coronary artery or by-pass surgery -Diagnosis: -Date of surgery (attach copy of discharge summary): -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications): -Current status: -Limitations or restrictions of ADLs: -Current height/weight: -Blood pressure: -Pulse rate and rhythm: -Smoking history: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: - copy of most recent ECG with interpretation

3 Coronary artery or heart by-pass surgery

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	- results of stress test done within past twelve months (Bruce protocol; if Bruce protocol inconclusive, a thallium stress test is required), .results of ejection fraction studies done post-procedure -results of most recent lipid profile Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * coronary artery or by-pass surgery

(*4*) *Coronary angioplasty ("balloon angioplasty") or insertion of stent(s)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
129	Cardiovascular	24 4	Y						PND	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist or cardiovascular surgeon. 2 * Condition reported: coronary angioplasty -Diagnosis: -Date of surgery (attach copy of discharge summary): -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications):

4 Coronary angioplasty ("balloon angioplasty") or insertion of stent(s)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Current status: -Limitations or restrictions of ADLs: -Current height/weight: -Blood pressure: -Pulse rate and rhythm: -Smoking history: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: - copy of most recent ECG with interpretation - results of stress test done within past twelve months (Bruce protocol; if Bruce protocol inconclusive, a thallium stress test is required), results of ejection fraction studies done post-procedure -results of most recent lipid profile Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * coronary angioplasty

(*5*) *Other heart surgery*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text

5 Other heart surgery

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
131	Cardiovascular	24 5	Y						PND	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist or cardiovascular surgeon. 2 * Condition reported: other heart surgery -Diagnosis: -Procedure performed: -Date of procedure (attach copy of discharge summary): -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications): -Current status: -Limitations or restrictions of ADLs: -Current height/weight: -Blood pressure: -Pulse rate and rhythm: -Smoking history: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years:

5 Other heart surgery

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Attach: - copy of most recent ECG with interpretation - results of stress test done within past twelve months (Bruce protocol; if Bruce protocol inconclusive, a thallium stress test is required). -results of most recent lipid profile. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * other heart surgery

(6) Carotid artery surgery

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
135	Cardiovascular	24 6	Y						PND	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist, cardiovascular or vascular surgeon. 2 * Condition reported: carotid artery surgery -Diagnosis: -Date of procedure (attach copy of discharge summary): -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications):

6 Carotid artery surgery

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Current status: -Limitations or restrictions of ADLs: -Current height/weight: -Blood pressure: -Pulse rate and rhythm: -Smoking history: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: - copy of most recent ECG with interpretation - results of stress test done within past twelve months (Bruce protocol; if Bruce protocol inconclusive, a thallium stress test is required) - results of most recent lipid profile Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND 1	* carotid artery surgery

(*7*) *Other surgery of the arteries*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
138	Cardiovascular	24 7	Y						PND	00	EVALFORM 1	This evaluation must be completed by a

7 Other surgery of the arteries

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	cardiology specialist, cardiovascular or vascular surgeon. 2 * Condition reported: unspecified surgery of the arteries -Procedure performed and date of surgery (attach copy of discharge summary): -Treatment (incl. medications): -Current status: -Limitations or restrictions of ADLs: -Current height/weight: -Blood pressure: -Pulse rate and rhythm: -Smoking history: -Specific requirements for follow-up over next three years: -Attach: - copy of most recent ECG with interpretation - results of stress test done within past twelve months (Bruce protocol; if Bruce protocol inconclusive, a thallium stress test isrequired) - results of most recent lipid profile Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?

7 Other surgery of the arteries

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											PND	1 * unspecified surgery of the arteries

 # 25 Do you have or have you ever had:

(*1*) *A pacemaker*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
134	Cardiovascular	25 1	Y						PND	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist. 2 * Condition reported: pacemaker -Initial onset of symptoms: -Description of current symptoms: -Etiology/reason for pacemaker insertion: -Current treatment (include medications, diet, exercise): -Limitations or restrictions of Activities of Daily Living: -Altitude restriction required? (CIRCLE ONE) YES NO -Specific requirements for follow-up over next three years: -Attach: - copy of current ECG with interpretation - copy of operative report or hospital discharge summary (incl. identifying characteristics of pacemaker) -results of stress test, Bruce protocol (if done within last two years) -results of most recent chest x-ray Were the above responses based on (please

1 A pacemaker

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * a cardiac pacemaker

(2) Coronary artery disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
122	Cardiovascular	25 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist. 2 * Condition reported: coronary artery disease -Diagnosis: -Date of onset: -Symptoms: -Frequency of symptoms: -Severity: -Diagnosis of CAD confirmed by: Stress Test YES NO Angiogram YES NO -Current status: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Likelihood of need for surgical intervention within next three years:

2 Coronary artery disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Specific requirements for follow-up over next three years: Attach: copies of all pertinent laboratory and diagnostic test reports. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Condition reported: Coronary artery disease - an evaluation by a specialist has been requested.

(*3*) *Congestive heart failure*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
123	Cardiovascular	25 3	Y						PND	00	EVALFORM 1	This evaluation must be completed by a cardiology specialist.
											2	* Condition reported: congestive heart failure -Initial onset of symptoms: -Description of current symptoms: -Etiology: -Current treatment (include medications, diet, exercise): -Limitations or restrictions of Activities of Daily Living: -Altitude restriction required? (CIRCLE ONE) YES NO

3 Congestive heart failure

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Specific requirements for follow-up over next three years: -Attach: - copy of most recent ECG with interpretation within the past 1 year - copy of echocardiogram, or equivalent diagnostic test, with the past 1 year -copy of chest x-ray report with interpretation within the past 1 year If applicable: -Copy of the most recent stress test with interpretation (Bruce protocol). If Bruce protocol is inconclusive, copy of thallium stress test results with interpretation. -Discharge summary for all related hospitalizations. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * congestive heart failure

(*4*) *A disturbance of heart rhythm (arrhythmia)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
142	Cardiovascular	25 4	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist. 2 * Condition reported: disturbance of heart rhythm (arrhythmia) -Diagnosis:

4 A disturbance of heart rhythm (arrhythmia)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Etiology: -Date of onset: -Symptoms -Frequency of symptoms: -Severity: -Treatment (incl. medications): -Current status: -Specific requirements for follow-up over next three years: -Limitations or restrictions on ADLs: -Attach: - copy of most recent ECG with interpretation within the past year If applicable for Diagnosis: -Electrophysiologic studies -Copy of most recent Holtor Monitor with interpretation (required with all A-V blocks and LBBB and Hemiblocks) -Copy of most recent stress test results with interpretation (Bruce protocol). If Bruce protocol is inconclusive, copy of thallium stress test with interpretation -Copy of echocardiogram, or equivalent diagnostic test, within the past year -Need for radiofrequency catheter ablation over the next 3 years (Information

4 A disturbance of heart rhythm (arrhythmia)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	required for W-P-W) -Discharge summary of all related hospitalizations. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Condition reported: heart rhythm (arrhythmia) - an evaluation by a specialist has been requested.

(*5*) *An aneurysm*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
144	Cardiovascular	25 5	Y						PND	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist. 2 * Condition reported: an aneurysm -Diagnosis: -Location of aneurysm: -Etiology: -Date of onset: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications and surgical intervention) (attach copy of discharge summary for surgical procedures):

5 An aneurysm

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Limitations or restrictions of ADLs: -Requirement for SBE prophylaxis: (Circle One) YES NO -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: - copy of results of most recent stress test (Bruce protocol) - vascular flow studies - lipid profile Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND 1	* an aneurysm

 # 26 Do you have or have you ever had:

(*1*) *A heart murmur present after age 15*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
143	Cardiovascular	26 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Heart murmur present after age 15 -Type and grade:

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1 A heart murmur present after age 15

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Etiology, if known: -Symptoms: -Severity: -Treatment (incl. need for SBE prophylaxis): -Current status: -Likelihood of progression over next three years: -Specific requirements for follow-up over next three years: -Specify any history of MVP: -Attach: copy of results of any/most recent cardiology evaluation and echocardiogram if done.

(*2*) *Heart valve disease*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
145	Cardiovascular	26 2	Y						PND	00	EVALFORM	1 This evaluation must be completed by a cardiology specialist. 2 * Condition reported: heart valve disease -Onset and severity of symptoms: -Presence and severity of murmur: -Diagnosis and etiology if known: -Treatment (incl. medications and surgical procedures) -Current status, incl. limitations or restrictions on ADLs or altitude:

2 Heart valve disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Requirement for SBE prophylaxis: YES NO -Specific requirements for follow-up over next three years: -Attach: - operative report and discharge summary for any operative procedures - copy of recent ECG with interpretation done within the past year If applicable: -copy of most recent echocardiogram if surgery within past 2 years - results of most recent chest x-ray Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * heart valve disease

(3) Mitral valve prolapse

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
620	Cardiovascular	26 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Mitral Valve Prolapse -Etiology -Signs and symptoms (inc. clicks, murmurs-grade), and date last noted Please note any mitral valve regurgitation and/or left ventricular

3 Mitral valve prolapse

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	hypertrophy. -Treatment (inc. treatment dates, and current medication[s]) -Current status -Need for SBE prophylaxis -Restrictions or limitations in activity -Attach copy of EKG with interpretation within the past 2 years -If over age 50 or with symptoms of mitral valve regurgitation and/or left ventricualr hypertrophy: Attach a copy of an echocardiogram, or equivalent diagnostic test, report done within the past 1 year. -Recommendations for follow up over the next three years

(*4*) *A blood clot in the lung (pulmonary embolism)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
146	Cardiovascular	26 4	Y						PND	00	EVALFORM	1 This evaluation must be completed by an internist or cardiovascular specialist. 2 * Condition reported: blood clot in the lungs (pulmonary embolism) -Etiology , if known (i.e. Oral contraceptives, Factor V Leiden, etc) -Date of episode: -Number of episodes: -Treatment (incl. medications):

4 A blood clot in the lung (pulmonary embolism)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Current status: -Specific requirements for follow-up over next three years: -Attach: - copy of most recent ECG with interpretation - pulmonary function studies -Lab Reports (if applicable for blood clotting deficiency) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * blood clot in the lungs (pulmonary embolism)

(*5*) *Thrombophlebitis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
147	Cardiovascular	26 5	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an internist or cardiovascular specialist. 2 * Condition reported: thrombophlebitis -Etiology, precipitating factors -Date of last episode: -Number of episodes: -Treatment (include medications; attach copy of discharge summary if hospitalized) -Current status:

5 Thrombophlebitis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Specific requirements for follow-up over next three years: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding thrombophlebitis.

(*6*) *Problems caused by poor circulation*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
141	Cardiovascular	26 6	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Problems caused by poor circulation -Diagnosis: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Restrictions/limitations: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status -Specific requirements for follow-up over

6 Problems caused by poor circulation

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	next three years -Attach: copy of results of any diagnostic studies performed

27 Other than aspirin, do you currently take any blood-thinning(anti-coagulant) medication such as Warfarin or Coumadin?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
150	Cardiovascular	27 0	Y						PND	00	EVALFORM	1 This evaluation must be completed by an internist, neurologist, cardiologist, cardiovascular surgeon or other specialist prescribing anti-coagulant therapy. 2 * Condition reported: Blood thining medication -Diagnosis: -Reason for anti-coagulation therapy: -Date anti-coagulation therapy initiated: -Medication regimen (name, dose, frequency of medication): -Current status: -Specific requirements for follow-up over next three years: -Attach pertinent laboratory tests, diagnostic studies, and discharge summary if hospitalized Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * take an anti-coagulant medication

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28 Do you have or have you ever had any other heart or circulatory condition or surgery not listed in items 22-27?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
154	Cardiovascular	28 0	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a cardiac (medical or surgical) specialist. 2 * Condition reported: some other heart or circulatory condition -Diagnosis: -Date of onset: -Etiology: -Complications: -Symptoms: -Frequency of symptoms: -Severity: -Treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of most recent ECG report with interpretation. -Copies of all pertinent laboratory and diagnostic test reports -Copy of hospital discharge summary report, if applicable. Were the above responses based on (please check one):

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding some other heart or circulatory condition.

 # 29 Do you have or have you ever had:

(*1*) *An esophageal stricture*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
156	Gastroenterology	29 1	Y						FLG	00	EVALFORM 1	This evaluation must be completed by a gastroenterology specialist.
											2	* Condition reported: esophageal stricture -Date of diagnosis: -Etiology: -Symptoms: -Severity of symptoms: -Treatment: -Current status -History of recurrence -Limitations/restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Recommendations for follow-up over next 3 years

1 An esophageal stricture

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Attach: Copy of diagnostic endoscopy report CBC If Applicable, endoscopy results within 6 months of departure for Barrett's esophagus Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding esophageal stricture.

(*2*) *Esophageal varices*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
157	Gastroenterology	29 2	Y						FLG	00	EVALFORM 1	This evaluation must be completed by a gastroenterology specialist.
											2	* Condition reported: esophageal varices -Diagnosis: -Date of onset: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone

2 Esophageal varices

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: Attach: -Copies of all pertinent laboratory and diagnostic test reports -Copy of most recent endoscoy -A thorough alcohol history is necessary if alcohol is the underlying cause Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding esophageal varices.

(3) Stomach or duodenal ulcers(peptic ulcer disease)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
158	Gastroenterology	29 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Stomach or duodenal ulcers (peptic ulcer disease) -Diagnosis: -Date of onset: -Symptoms: -Frequency of symptoms: -Severity of symptoms:

3 Stomach or duodenal ulcers(peptic ulcer disease)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Restrictions/ ADL limitations: -Current status: -Treatment: -medications -diet restrictions -other: -Number of contacts (e.g. visits and telephone contacts) with patient for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: copy of results of test for occult blood x 3: copy of results of most recent endoscopy, if done (required for gastric ulcer) copy of any other pertinent diagnostic test reports

(*4*) *Cirrhosis of the liver*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
160	Gastroenterology	29 4	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a gastroenterology specialist. 2 * Condition reported: cirrhosis of the liver -Diagnosis: -Etiology (include alcohol and infectious disease history): -Symptoms:

4 Cirrhosis of the liver

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Severity of symptoms: -Physical exam findings: -Treatment (include surgical procedures and medications): -Co-morbidity, (e.g. clotting disorder or portal hypertension): -Current status: -Limitations/ADL restrictions: -Number of contacts (e.g. visits and telephone contacts) with patient for this condition in the last 12 months: -Specific requirements for follow-up over next three years (include medications, labs and any dietary limitations): -Attach: - copy of hospital discharge summary, if applicable - results of most recent liver profile (within past three months) - results of any other pertinent laboratory or diagnostic studies Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding cirrhosis of the liver.

(*5*) *Pancreatic disease*

5 Pancreatic disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
163	Gastroenterology	29 5	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a gastroenterology specialist. 2 * Condition reported: acute pancreatic disease -Diagnosis: -Date of onset: -Date of resolution: -History of reoccurrence: -Number of episodes: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Diet: -Medications: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years:

5 Pancreatic disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Specific requirements for follow-up over next three years: Attach: -Copy of discharge summary if hospitalized. -Copy of current CBC, Amylase and Lipase laboratory reports. -Copy of all other pertinent laboratory and diagnostic test reports. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding pancreatic disease

(*6*) *Diverticulosis/diverticulitis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
164	Gastroenterology	29 6	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Condition Reported: Diverticulosis/diverticulitis -Diagnosis (rule-out Irritable Bowel Syndrome): -Date of onset: -Etiology: -Symptoms: -Severity of symptoms: -# of episodes:

6 Diverticulosis/diverticulitis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Date of last episode: -Current treatment: -Diet: -Medications: -Limitations/ADL restrictions: -Number of times (e.g. visits, hospitalizations, and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: Copies of all diagnostic test reports (e.g. colonoscopy, barium study, radiology, etc.) Copies of Stool for occult blood x 3. Copy of CBC Copies of all operative, biopsy/pathology reports, if applicable

 # 30 Do you currently have:

(*1*) *A hernia of the groin (inguinal) or abdomen*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
167	Gastroenterology	30 1	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a surgeon. 2 * Condition reported: a hernia of the groin (inguinal hernia) or abdomen -Diagnosis/hernia type:

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1 A hernia of the groin (inguinal) or abdomen

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Date of diagnosis: -Location: -Etiology: -Size of hernia: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Current treatment: -Surgery: -Diet restrictions: -Medications: -Assessment of risk for strangulation: -Date of repair: -Need for surgical repair within the next three years: -Specific recommendation for follow-up over the next three years: Attach: Surgical report (if applicable) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	

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1 A hernia of the groin (inguinal) or abdomen

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	1 * Specialist evaluation requested regarding a hernia of the groin or abdomen.

(2) A colostomy or an ileostomy

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
168	Gastroenterology	30 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a gastroenterology specialist. 2 * Condition reported: colostomy or ileostomy -Diagnosis: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (include surgical procedures and medications): -Current status: -Assessment of applicant's ability to self-manage ostomy in medically austere, unsanitary environment: -Specific requirements for follow-up over next three years (include medications and any dietary limitations): -Attach: copy of hospital discharge summary, results of most recent colonoscopy, results of any other pertinent laboratory or diagnostic studies Were the above responses based on (please

2 A colostomy or an ileostomy

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested for colostomy or ileostomy.

 # 31 Have you had two or more episodes of a cyst near the rectum (pilonidal cyst)?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
169	Gastroenterology	31 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Two or more episodes of a cyst near the rectum (pilonidal cyst) -Diagnoses: -Date of diagnosis: -Etiology: -Number of episodes: -Date or resolution: -Symptoms: -Frequency of symptoms: -Severity: -Treatment: -Type of surgery, if applicable: -Date of surgery, if applicable: -Number of times (e.g. visits and telephone contacts) patient

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of need for surgery over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copies of all pertinent laboratory and diagnostic test reports. -Copies of all operative and pathology reports, if applicable.

 # 32 Do you have or have you ever had any other conditions or surgery of the esophagus, stomach, liver, gall bladder, pancreas or intestinal tract not listed in items 29-31?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
165	Gastroenterology	32 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Unspecified gastrointestinal condition or surgery of the esophagus, stomach, liver, gall bladder, pancreas or intestinal tract - Diagnosis: - Date of diagnosis: - Symptoms: - Frequency of symptoms: - Severity of symptoms: -Date of resolution -History of recurrence(s): - Current status:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	- Limitations/restrictions: - Treatment plan: -Diet: -Medications: - Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: - Recommendations for follow-up for the next three years - Attach: Report of imaging studies (upper GI, ultrasound, abdominal CT, colonoscopy, or any other imaging studies used to make diagnosis), if applicable. - Attach: CBC, TSH, Sedimentation rate, if applicable - Attach: Detailed personal statement about symptom management

 # 33 (Males only for this question) Have you ever had:

(*2*) *An enlarged prostate*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
9	Genito-urinary	33 1	Y	M					FLG	00	EVALFORM	1 This evaluation must be completed by a urology specialist. 2 * Condition reported: Difficulty starting or stopping urine stream -Applicant and Physician: complete special WHOOPS form.
		33 2	N	M								

2 An enlarged prostate

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	In addition: -Diagnosis/etiology: -Symptoms and severity: -Treatment (include any medications and/or surgery): -Current status: -Specific recommendations for follow-up over next three years (incl. assessment of need for surgery.) -Attach: - copy of results of current PSA (if >4, copy of sonogram results required) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* difficulty starting or stopping urine stream - evaluation by an urologist has been requested
											FORM-WHOPS	
10	Genito-urinary	33 1 33 2	Y Y	M M					FLG	00	EVALFORM 1 2	This evaluation must be completed by a urology specialist. * Condition reported: Difficulty starting and/or stopping urine stream and an enlarged prostate -Diagnosis, onset and date of dx -Current status:

2 An enlarged prostate

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms		Insert # and Text
											EVALFORM		-Specific recommendations for follow-up over next three years -Attach copies of: - Discharge summary if hospitalized and/or surgery - Results of current microscopic urinalysis - Results of any pertinent laboratory or diagnostic procedures -Attach: Results of most recent PSA (if >4, copy of sonogram results required). Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP		
											FLAGDKTR	1	* difficulty starting or stopping urine stream and an enlarged prostate - evaluation by an urologist has been requested
											FORM-WHOPS		
12	Genito-urinary	33 1 33 2	N Y						FLG	00	EVALFORM	1 2	This evaluation must be completed by a urology specialist. * Condition reported: An enlarged prostate -Diagnosis: -Date of dx: -Date of resolution: -Symptoms: -Frequency of symptoms:

2 An enlarged prostate

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Severity: -Treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific recommendations for follow-up over next three years -Attach copies of: - Discharge summary if hospitalized and/or surgery - Results of current microscopic urinalysis - Results of any pertinent laboratory or diagnostic procedures - Results of most recent PSA (if >4, copy of sonogram results required). Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding enlarged prostate.

(*3*) *Pain or swelling in your testicles*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
11	Genito-urinary	33 3	Y	M					FLG	00	FLAGAPP	

3 Pain or swelling in your testicles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	2 * Pain or swelling in testicles -Diagnosis: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (include medications): -Date and type of surgery, if applicable: -Current status: -Specific recommendations for follow-up over next three years: -Attach: - copy of results of pertinent laboratory tests, diagnostic procedures - discharge summary if hospitalized

(*4*) *Hydrocele, spermatocele or varicocele*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
640	Genito-urinary	33 4	Y	M					FLG	00	EVALFORM	1 This evaluation must be completed by an urologist. 2 * Condition reported: Hydrocele, spermatocele or varicocele -Diagnosis: -Date of onset: -Etiology:

4 Hydrocele, spermatocele or varicocele

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Date or resolution: -Symptoms: -Frequency of symptoms: -Severity: -Treatment -Current status: -Specific recommendations for follow-up over next three years -Attach copies of: Discharge summary if hospitalized and/or surgery Operative report, if applicable Results of current microscopic urinalysis Results of any pertinent laboratory or diagnostic procedures. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested for hydrocele, spermatocele or varicocele

 # 33 (Males only for this question.) have you ever had:

(1) Difficulty starting or stopping your urine stream

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
12	Genito-urinary	33 1	N						FLG	00	EVALFORM 1	This evaluation must be completed by a urology specialist.

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1 Difficulty starting or stopping your urine stream

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
		33 2	Y								EVALFORM	2 * Condition reported: An enlarged prostate -Diagnosis: -Date of dx: -Date of resolution: -Symptoms: -Frequency of symptoms: -Severity: -Treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific recommendations for follow-up over next three years -Attach copies of: - Discharge summary if hospitalized and/or surgery - Results of current microscopic urinalysis - Results of any pertinent laboratory or diagnostic procedures - Results of most recent PSA (if >4, copy of sonogram results required). Were the above responses based on (please check one): ___ An historical evaluation?

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1 Difficulty starting or stopping your urine stream

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
												EVALFORM	___ A current evaluation?
												FLAGAPP	
												FLAGDKTR	1 * Specialist evaluation requested regarding enlarged prostate.
9	Genito-urinary	33	1	Y	M					FLG	00	EVALFORM	1 This evaluation must be completed by a urology specialist. 2 * Condition reported: Difficulty starting or stopping urine stream -Applicant and Physician: complete special WHOOPS form. In addition: -Diagnosis/etiology: -Symptoms and severity: -Treatment (include any medications and/or surgery): -Current status: -Specific recommendations for follow-up over next three years (incl. assessment of need for surgery.) -Attach: - copy of results of current PSA (if >4, copy of sonogram results required) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
		33	2	N	M								
												FLAGAPP	
												FLAGDKTR	1 * difficulty starting or stopping urine

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1 Difficulty starting or stopping your urine stream

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text	
												FLAGDKTR		stream - evaluation by an urologist has been requested
												FORM-WHOPS		
10	Genito-urinary	33	1	Y	M					FLG	00	EVALFORM	1	This evaluation must be completed by a urology specialist.
		33	2	Y	M								2	* Condition reported: Difficulty starting and/or stopping urine stream and an enlarged prostate -Diagnosis, onset and date of dx -Current status: -Specific recommendations for follow-up over next three years -Attach copies of: - Discharge summary if hospitalized and/or surgery - Results of current microscopic urinalysis - Results of any pertinent laboratory or diagnostic procedures -Attach: Results of most recent PSA (if >4, copy of sonogram results required). Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
												FLAGAPP		
												FLAGDKTR	1	* difficulty starting or stopping urine stream and an enlarged prostate - evaluation by an urologist has been requested

1 Difficulty starting or stopping your urine stream

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FORM-WHOPS	

 # 34 (Males only for this question) Within the last 5 years, have you had any other genital condition or surgery not listed in item 33?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
601	Genito-urinary	34 0	Y	M					FLG	00	FLAGAPP	
											FLAGDKTR	2 *Condition Reported: Unspecified male genital condition or surgery -Diagnosis: -Date of onset: -Date of resolution: -Etiology -Symptoms: -Frequency of symptoms: -Severity: -Treatment(s) w/dates: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow up over the next three years:

 # 35 (Female only for this question.) Are you currently using:

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(1) *Birth control injections (such as Depo-Provera)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
23	Gynecology	35 1	Y	F					FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Birth control injections (such as Depo-Provera) -Name: -Strength: -Date injections initiated: -Date of last injection: -Projected dates (month) of injections for next 12 months: -Current menstrual pattern: -Complications: -Specific requirements for follow up over the next three years

(2) *Other birth control methods*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
26	Gynecology	35 2	Y	F					FLG	00	FLAGAPP	
											FLAGDKTR	2 *Condition Reported: Other Birth Control Method - Type of birth control: - Name and strength: -If applicable, date of insertion or injection: -Current menstrual pattern: -Complications, if any:

2 Other birth control methods

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Specific requirements for follow up, including removal of an IUD (if applicable), over the next three years -PLEASE NOTE PEACE CORPS WILL USE THE GENERIC EQUIVALENT FOR ORAL CONTRACEPTIVES.

 # 36 (Female only for this question.)

(1) Have you ever had a pap smear?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
22	Gynecology	36 1	N	F					FLG	00	FLAGAPP	
											FLAGDKTR	1 * Has not had a pap smear. A pap smear is required as part of the Peace Corps medical application.

(2) If yes, have you ever had an abnormal Pap smear?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
21	Gynecology	36 2	Y	F					FLG	00	EVALFORM	1 This evaluation must be completed by a gynecology specialist or primary physician 2 *Condition reported: Abnormal PAP Smear If abnormal smear(s) within the past 3 years: - Diagnosis - Date(s) of diagnosis - Treatment - Date(s) of treatment - Specific requirements for follow-up

2 If yes, have you ever had an abnormal Pap smear?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	over the next three years. - Copy of all pap smear reports for the past 3 years If ASC-US on current PAP submit results of HPV DNA testing If applicable: Copy of colposcopy and biospy report(s) Copy of pathology reports If abnormal smear(s) greater than 3 years ago AND history includes HGSIL (CIN II or CIN III or moderate or severe dysplasia) or cancer (AIS or invasive carcinoma): - Diagnosis - Date(s) of diagnosis - Treatment - Date(s) of treatment - Specific requirements for follow-up over the next three years.
											FLAGAPP	
											FLAGDKTR 1	* Abnormal PAP smear - evaluation by a gynecology specialist or primary physician has been requested.

 # 37 (Female only for this question.) Do you have or have you ever had:

(1) PID (pelvic inflammatory disease) or tubal infections

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
24	Gynecology	37 1	Y	F					FLG	00	FLAGAPP	

1 PID (pelvic inflammatory disease) or tubal infections

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	2 * Pelvic inflammatory disease -Diagnosis: -Number of episodes: -Date of last episode: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications): -Post-treatment complications if any, to include chronic pelvic pain: -Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific recommendations for follow-up over the next three years: -Attach: - discharge summaries for all related hospitalizations if applicable -copies of all pertinent laboratory and diagnostic test reports.

(*2*) *Uterine fibroids*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
25	Gynecology	37 2	Y	F					FLG	00	EVALFORM	1 This evaluation must be completed by a gynecology specialist or primary physician

2 Uterine fibroids

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	2 * Condition Reported: Uterine Fibroids -Diagnosis: -Date of onset: -Symptoms: -Frequency of symptoms: -Severity: -Clinical evidence of GI, GU, or GYN obstruction: -Treatment history: -Medications: -Surgery: -Current treatment: -Assess stability of fibroids over past six months: -Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Assessment of need for medical intervention over the next three years: -Specific recommendations for follow-up over next three years: -Attach: -Copy of most recent ultrasound with interpretation to include size, location and number of fibroids.

2 Uterine fibroids

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Copy of all other pertinent diagnostic test reports. -Copy of discharge summary for all related hospitalizations, if applicable. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested for uterine fibroids.

(*3*) *Endometriosis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
27	Gynecology	37 3	Y	F					FLG	00	EVALFORM 1	This evaluation must be completed by a gynecology specialist.
											2	* Condition Reported: Endometriosis -Diagnosis: Circle one: presumed or surgically confirmed -Number of episode(s): -Date of last episode: -Surgical stage, if available -Symptoms: -Frequency of symptoms: -Severity: -Treatment:

3 Endometriosis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Medications: -Date of treatment: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific recommendations for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports -Copy of most recent laparoscopy report with interpretation, if applicable. -Copy of all other operative and pathology reports, if applicable. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* endometriosis - evaluation by a specialist has been requested

38 (Female only for this question.) Do you currently have:

(*1*) *Menstrual cycles*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
18	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR 2	* Irregular menstrual cycles with breakthrough bleeding or spotting
		38 3	Y	F								

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1 Menstrual cycles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
32	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR 2	* Irregular menstrual cycles with breakthrough bleeding or spotting -Diagnosis: -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years:
		38 3	Y	F								

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1 Menstrual cycles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Attach copies of any related diagnostic tests:
31	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR	2 * Irregular menstrual cycles -Diagnosis: -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
		38 3	N	F								
33	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	N	F							FLAGDKTR	2 * Menstrual periods with breakthrough bleeding or spotting -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles:
		38 3	Y	F								

1 Menstrual cycles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
16	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR 2	* Irregular menstrual cycles -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
		38 3	N	F								
550	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	N	F							FLAGDKTR 2	* Bleeding or spotting between menstrual cycles. -Description of bleeding pattern: -Etiology:
		38 3	Y	F								

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1 Menstrual cycles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:

(*2*) *Irregular menstrual cycles (NOT monthly)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
32	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR	2 * Irregular menstrual cycles with breakthrough bleeding or spotting -Diagnosis: -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years:
		38 3	Y	F								

2 Irregular menstrual cycles (NOT monthly)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Attach copies of any related diagnostic tests:
550	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	N	F							FLAGDKTR 2	* Bleeding or spotting between menstrual cycles. -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
		38 3	Y	F								
31	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR 2	* Irregular menstrual cycles -Diagnosis: -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications:
		38 3	N	F								

2 Irregular menstrual cycles (NOT monthly)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
18	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR 2	* Irregular menstrual cycles with breakthrough bleeding or spotting -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
		38 3	Y	F								
16	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR 2	* Irregular menstrual cycles -Description of bleeding pattern: -Etiology: -Date of onset:
		38 3	N	F								

2 Irregular menstrual cycles (NOT monthly)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
33	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	N	F							FLAGDKTR	2 * Menstrual periods with breakthrough bleeding or spotting -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
		38 3	Y	F								

(*3*) *Bleeding or spotting between menstrual cycles*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text

3 Bleeding or spotting between menstrual cycles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
16	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR	2 * Irregular menstrual cycles -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
		38 3	N	F								
18	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR	2 * Irregular menstrual cycles with breakthrough bleeding or spotting -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over
		38 3	Y	F								

3 Bleeding or spotting between menstrual cycles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	the next three years: -Attach copies of any related diagnostic tests:
550	Gynecology	38 1	N	F					FLG	00	FLAGAPP	
		38 2	N	F							FLAGDKTR 2	* Bleeding or spotting between menstrual cycles. -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
		38 3	Y	F								
31	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR 2	* Irregular menstrual cycles -Diagnosis: -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles:
		38 3	N	F								

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3 Bleeding or spotting between menstrual cycles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
33	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	N	F							FLAGDKTR	2 * Menstrual periods with breakthrough bleeding or spotting -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:
		38 3	Y	F								
32	Gynecology	38 1	Y	F					FLG	00	FLAGAPP	
		38 2	Y	F							FLAGDKTR	2 * Irregular menstrual cycles with breakthrough bleeding or spotting
		38 3	Y	F								

3 Bleeding or spotting between menstrual cycles

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Diagnosis: -Description of bleeding pattern: -Etiology: -Date of onset: -Duration of irregular cycles: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copies of any related diagnostic tests:

 # 39 (Female only for this question.) Are you:

(*1*) *Post-menopausal NOT due to removal of uterus (hysterectomy)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
551	Gynecology	39 1	N	F					FLG	00	FLAGAPP	
		39 2	N	F							FLAGDKTR	1 * receiving hormone replacement therapy
		39 3	Y	F								
34	Gynecology	39 1	Y	F					FLG	00	FLAGAPP	
		39 2	N	F							FLAGDKTR	1 * post-menopausal
		39 3	N	F								
35	Gynecology	39 1	Y	F					FLG	00	EVALFORM	1 This evaluation must be completed by a gynecology specialist. 2 * Condition reported: bleeding or spotting after menopause, without hormone replacement therapy
		39 2	Y	F								
		39 3	N	F								

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1 Post-menopausal NOT due to removal of uterus (hysterectomy)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding post-menopausal NOT due to removal of uterus.
553	Gynecology	39 1 39 2 39 3	N Y Y	F F F					FLG	00	EVALFORM 1 2	This evaluation must be completed by a gynecology specialist. * Condition reported: bleeding or spotting after menopause, with hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern:

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1 Post-menopausal NOT due to removal of uterus (hysterectomy)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding vaginal bleeding or spotting after menopause, with HRT.
36	Gynecology	39 1	Y	F					FLG	00	FLAGAPP	
		39 2	N	F							FLAGDKTR 1	* post menopausal and receiving hormones
		39 3	Y	F								
37	Gynecology	39 1	Y	F					FLG	00	EVALFORM 1	This evaluation must be completed by a gynecology specialist.
		39 2	Y	F							2	* Condition reported: bleeding or spotting after menopause, with hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan:
		39 3	Y	F								

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1 Post-menopausal NOT due to removal of uterus (hysterectomy)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding vaginal bleeding or spotting after menopause, with HRT.
552	Gynecology	39 1 39 2 39 3	N Y N	F F F					FLG	00	EVALFORM 1 2	This evaluation must be completed by a gynecology specialist. * Condition reported: bleeding or spotting after menopause, without hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent

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1 Post-menopausal NOT due to removal of uterus (hysterectomy)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding Post-menopausal with vaginal bleeding or spotting without receiving hormone replacement therapy.

(*2*) *Post-menopausal with any vaginal bleeding or spotting*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
551	Gynecology	39 1	N	F					FLG	00	FLAGAPP	
		39 2	N	F							FLAGDKTR 1	* receiving hormone replacement therapy
		39 3	Y	F								
37	Gynecology	39 1	Y	F					FLG	00	EVALFORM 1	This evaluation must be completed by a gynecology specialist.
		39 2	Y	F							2	* Condition reported: bleeding or spotting after menopause, with hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over
		39 3	Y	F								

2 Post-menopausal with any vaginal bleeding or spotting

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding vaginal bleeding or spotting after menopause, with HRT.
35	Gynecology	39 1 39 2 39 3	Y Y N	F F F					FLG	00	EVALFORM 1 2	This evaluation must be completed by a gynecology specialist. * Condition reported: bleeding or spotting after menopause, without hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed:

2 Post-menopausal with any vaginal bleeding or spotting

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding post-menopausal NOT due to removal of uterus.
34	Gynecology	39 1	Y	F					FLG	00	FLAGAPP	
		39 2	N	F							FLAGDKTR 1	* post-menopausal
		39 3	N	F								
36	Gynecology	39 1	Y	F					FLG	00	FLAGAPP	
		39 2	N	F							FLAGDKTR 1	* post menopausal and receiving hormones
		39 3	Y	F								
553	Gynecology	39 1	N	F					FLG	00	EVALFORM 1	This evaluation must be completed by a gynecology specialist.
		39 2	Y	F							2	* Condition reported: bleeding or spotting after menopause, with hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed:
		39 3	Y	F								

2 Post-menopausal with any vaginal bleeding or spotting

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding vaginal bleeding or spotting after menopause, with HRT.
552	Gynecology	39 1 39 2 39 3	N Y N	F F F					FLG	00	EVALFORM 1 2	This evaluation must be completed by a gynecology specialist. * Condition reported: bleeding or spotting after menopause, without hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?

2 Post-menopausal with any vaginal bleeding or spotting

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding Post-menopausal with vaginal bleeding or spotting without receiving hormone replacement therapy.

(3) Receiving hormone replacement therapy (HRT)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
37	Gynecology	39 1	Y	F					FLG	00	EVALFORM	1 This evaluation must be completed by a gynecology specialist. 2 * Condition reported: bleeding or spotting after menopause, with hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
		39 2	Y	F								
		39 3	Y	F								

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3 Receiving hormone replacement therapy (HRT)

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
												FLAGAPP	
												FLAGDKTR	1 * Specialist evaluation requested regarding vaginal bleeding or spotting after menopause, with HRT.
36	Gynecology	39	1	Y	F					FLG	00	FLAGAPP	
		39	2	N	F							FLAGDKTR	1 * post menopausal and receiving hormones
		39	3	Y	F								
35	Gynecology	39	1	Y	F					FLG	00	EVALFORM	1 This evaluation must be completed by a gynecology specialist. 2 * Condition reported: bleeding or spotting after menopause, without hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
		39	2	Y	F								
		39	3	N	F								
												FLAGAPP	

3 Receiving hormone replacement therapy (HRT)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	1 * Specialist evaluation requested regarding post-menopausal NOT due to removal of uterus.
553	Gynecology	39 1 39 2 39 3	N Y Y	F F F					FLG	00	EVALFORM	1 This evaluation must be completed by a gynecology specialist. 2 * Condition reported: bleeding or spotting after menopause, with hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding vaginal bleeding or spotting after menopause, with HRT.
551	Gynecology	39 1 39 2 39 3	N N Y	F F F					FLG	00	FLAGAPP	
											FLAGDKTR	1 * receiving hormone replacement therapy

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3 Receiving hormone replacement therapy (HRT)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
34	Gynecology	39 1	Y	F					FLG	00	FLAGAPP	
		39 2	N	F							FLAGDKTR	1 * post-menopausal
		39 3	N	F								
552	Gynecology	39 1	N	F					FLG	00	EVALFORM	1 This evaluation must be completed by a gynecology specialist. 2 * Condition reported: bleeding or spotting after menopause, without hormone replacement therapy -Etiology: -Date(s) of onset of symptoms: -Description of bleeding pattern: -Complications: -Management plan: -Current status: -Recommendations for follow-up over the next three years: -Attach copy of results of most recent Pap smear and other diagnostic studies if performed: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
		39 2	Y	F							FLAGAPP	
		39 3	N	F							FLAGDKTR	1 * Specialist evaluation requested regarding Post-menopausal with vaginal bleeding or spotting without receiving hormone replacement therapy.

40 (Female only for this question.) Have you had your uterus removed (Hysterectomy)?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
46	Gynecology	40 0	Y	F					FLG	00	FLAGAPP	
											FLAGDKTR	2 * Hysterectomy -Date of surgery: -Type of surgical procedure: -Reason for surgery: -Etiology, if known: -Post-surgical complications, if any: -Treatment, if any (eg: hormone replacement therapy); -Specific recommendations for follow-up over next three years: -Attach: - copy of pathology report if underlying malignant etiology -copy of most recent Pap Smear report if cervix is still present (or state why the Pap Smear is not indicated in this applicant). If surgery within past one (1) year attach: -Discharge summaries for all related hospitalizations: -Documentation of release from surgical care:

41 (Female only for this question.) Do you have or have you ever had:

(*1*) *A breast cyst or lump*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text

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1 A breast cyst or lump

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
602	Gynecology	41 1	Y	F					FLG	00	FLAGAPP	
											FLAGDKTR	2 * Breast cyst or lump -Specific diagnosis: -Date of diagnosis: -Size, location and number of cysts or mass: -Stability of cysts, i.e. change in size -History of breast cancer: -Tumor type: -Stage: - Number of positive lymph nodes, if known: -Treatment to include primary treatment, i.e., surgery; and adjuvant treatment, i.e., radiation, chemotherapy, and hormone therapy. Include date completed for each: -Current status to include history of recurrences: -Recommendations for follow-up over the next three years: - Copy of Mammogram report within the past year: -Copy of liver function tests (LFTs) within the past year: -Copy of ultrasound report within the past two years -If applicable, attach:

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1 A breast cyst or lump

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-copy of pathology report(s) of aspiration, biopsy or excision

(2) Fibrocystic breast changes

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
603	Gynecology	41 2	Y	F					FLG	00	FLAGAPP	
											FLAGDKTR	2 * Fibrocystic breast changes -Presence of any defined breast cyst or mass YES NO (if YES give size and location of all) -History of breast cancer -Recommendations for follow-up over the next three years -If applicable attach: - Copy of pathology report(s) of aspiration, biopsy or excision - Copy of most recent mammogram report - Copy of most recent ultrasound report

(3) Breast implants

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
643	Gynecology	41 3	Y	F					FLG	00	FLAGAPP	
											FLAGDKTR	2 * Breast implants -Date of implant: -History of Breast Cancer - Type, size, and location of implants,

3 Breast implants

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	- If within one year include hospital discharge summary, date of surgery, -Any post-surgical complications, -Recommendations for the next three years -Results of most recent mammogram post breast implant

 # 42 (Female only for this question.) Within the last 5 years, have you had any other gynecological conditions or surgery not listed in items 35-41?

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
48	Gynecology	42	0	Y	F					FLG	00	FLAGAPP	
												FLAGDKTR	2 * Other gynecological condition or surgery - Diagnosis: -Date of Diagnosis: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment: -Hormone replacement therapy: -Type of surgical procedure: -Date of treatment/surgery: -Complications:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific recommendations for follow-up over next three years: -Attach, if applicable: - copy of pathology report if underlying malignant etiology. - copy of most recent ultrasound report with interpretation. - copy of laparoscopy report with interpretation. - copy of discharge summaries for all related hospitalizations. - copy of any other pertinent diagnostic test reports.

43 Have you had four or more bladder infections (cystitis) in the past year?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
170	Genito-urinary	43 0	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an urologist. 2 * Condition reported: four or more bladder infections (cystitis) in the last year -Number of episodes in past year: -Date of last episode: -Symptoms: -Treatment (incl. medications):

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: - copy of results of current microscopic urinalysis - any other pertinent laboratory tests or diagnostic procedures Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding bladder infections

44 Have you had two or more kidney infections (pyelonephritis) in the past two years?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
171	Genito-urinary	44 0	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a nephrology (kidney) specialist. 2 * Condition reported: more than one kidney infection (pyelonephritis) in the last two years -Diagnosis: -Number of episodes: -Dates of episodes:

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Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Blood pressure results for prior 3 months: Date: BP: Date: BP: Date: BP: Date: BP: Date: BP: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: -Attach: - copy of results of current urine culture and sensitivity - copy of renal function tests (BUN, creatinine) - copy of other pertinent laboratory tests or diagnostic procedures - copy of related surgery reports (if applicable) or statement from treating specialist describing procedure and resolution

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested for more than one kidney infection (pyelonephritis) in the last two years .

45 Have you ever had kidney stones?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
174	Genito-urinary	45 0	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a urology specialist. 2 *Condition Reported: Kidney stone(s) -Diagnosis: -Date of onset: -Number of episodes: -Date of last episode: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment(s): -Date(s) of treatment: -Current status:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Specific requirements for follow-up within the next three years -Attach copies of: - copy of related laboratory results (UA, uric acid, creatinine) - copy of current KUB if done to rule-out current stone - discharge summary if hospitalized/surgery - related surgery and pathology reports, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	*Kidney stones - evaluation by a specialist has been requested

46 Do you have or have ever you had any urinary, bladder, or kidney condition or surgery not listed in items 43 - 45?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
180	Genito-urinary	46 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Unspecified urinary, bladder or kidney condition or surgery -Diagnosis: -Date of onset: -Etiology: -Symptoms: -Frequency of symptoms:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Severity: -Treatment -Current status -Specific recommendations for follow up over the next three years -Attach copies of: -discharge summary if hospitalized/surgery -results of current microscopic urinalysis -current KUB if done to rule-out current stone -results of any pertinent laboratory tests or diagnostic procedures

 # 47 Do you have or have you ever had:

(*1*) *Eczema or psoriasis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
183	Dermatology	47 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Eczema or psoriasis -Diagnosis (include type): -Date of diagnosis: -Location (include body map for psoriasis): -Symptoms: -Frequency of symptoms (include exacerbations): -Severity: -Etiology (for eczema):

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1 Eczema or psoriasis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Current treatment: -Medications (incl. topical and oral medications): -Treatment history (for psoriasis): -History of systemic steroid use: -Psoriatic arthritis to include location: -Nail involvement: -Restrictions, limitations to include climate, hygiene: -Specific requirements for follow-up over next three years:

(*2*) *Basal cell tumor(s) of the skin*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
184	Dermatology	47 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a dermatology or oncology (cancer) specialist. 2 * Condition reported: Basal cell tumor of the skin -Skin cancer history to include description, size, and location of lesion(s): -Date(s) of diagnosis(s): -Histologic type, if known: -Treatment:

2 Basal cell tumor(s) of the skin

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-History of same site recurrences: -Current status: -Specific requirements for follow-up over next three years: -Attach copy of pathology report (if lesion(s) within the past 2 years) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Condition Reported: Basal cell tumor of the skin -An evaluation by a specialist has been requested.

(*3*) *A cancerous mole or other skin cancer (not basal cell)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
284	Dermatology	47 3	Y						FLG	00	EVALFORM 1	This evaluation must be completed by a dermatology or oncology (cancer) specialist.
											2	* Condition reported: skin cancer or cancerous mole -Diagnosis: -Dates of diagnosis: -Date of resolution: -Specific location(s): -Description of lesion(s) to include size,

3 A cancerous mole or other skin cancer (not basal cell)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	location and tumor stage if applicable: -History of re-ocurrences(s), same site or other site: -Prognosis: -Treatment (incl. medications and any surgical procedure): -Specific requirements for follow-up over the next three years: -Attach: copy of pathology report(s), copy of discharge summary if hospitalized Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* skin cancer or cancerous mole - evaluation by a specialist has been requested

 # 48 Within the last 5 years, have you had any other skin condition not listed in item 47 for which you are taking prescription medication or receiving medical treatment?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
185	Dermatology	48 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Unspecified skin condition requiring prescription medication or medical treatment -Diagnosis: -If Acne diagnosis: (circle) Cystic Comedones Vulgaris

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Number of episodes: -Dates of episodes: -Symptoms: -Frequency of symptoms: -Severity: -Etiology: -Treatment: -Current status: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: copy of pathology report, if applicable copy of all pertinent laboratory and diagnostic test reports.

 # 49 Within the last 5 years, have you ever broken any of the following bones?

(*1*) *Back (spine) or neck*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
186	Orthopedics	49 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: fracture of the back (spine) or neck

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1 Back (spine) or neck

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Diagnosis: -Type of fracture: -Location: -Date of fracture: -Date of resolution: -Etiology: -Neurological involvement: -Treatment: -Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from

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1 Back (spine) or neck

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	hospitalization, if applicable -Copy of operative report, if applicable

(*2*) *Hip*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
648	Orthopedics	49 2 50 3 52 1	Y N Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if the surgery has been in the last year, otherwise this form may be completed by the primary physician. 2 * Condition reported: Fractured hip and hip reconstruction or replacement -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment/surgery: -Surgical procedure: -Limitations/ADL restrictions:

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2 Hip

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
												EVALFORM	-Need for brace or other orthotic device: -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization -Copy of operative report Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
												FLAGAPP	
												FLAGDKTR 1	* Specialist evaluation requested regarding fractured hip and hip reconstruction or replacement
654	Orthopedics	49	2	N						FLG	00	FLAGAPP	
		50	3	Y								FLAGDKTR 2	* Condition reported: Chronic hip pain -Diagnosis:
		52	1	N									

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2 Hip

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Affected side: -Etiology: -Date of onset: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports.
683	Orthopedics	49 2	N						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if fracture occurred

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2 Hip

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
		50 3	Y								EVALFORM	within the last year, otherwise it may be completed by the primary physician.
		52 1	Y									2 * Condition reported: Chronic hip pain and hip reconstruction or replacement -Diagnosis: -Affected side: -Etiology: -Date of onset: -Date of resolution: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Surgical procedure: -Date of treatment/surgery: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months:

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2 Hip

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
												EVALFORM	-Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization. -Copy of operative report. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
												FLAGAPP	
												FLAGDKTR 1	* Specialist evaluation requested regarding hip reconstruction or replacement with chronic hip pain.
647	Orthopedics	49 50 52	2 3 1	Y Y N						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if the fracture occurred in the last year, otherwise it may be completed by the primary physician.
												2	* Condition reported: fracture of hip and chronic hip pain -Diagnosis: -Affected side: -Date of fracture: -Etiology: -Symptoms: -Severity of symptoms:

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2 Hip

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
												EVALFORM	-Frequency of symptoms: -Treatment (incl. specific surgical procedure performed, if applicable): -Number of contacts (e.g. visits and telephone contacts) with patient for this condition in the last 12 months: -Current status: -Restrictions and ADL limitations: -Specific requirements for follow-up over next three years: -Attach: copies of all pertinent diagnostic test reports (Do not send films) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
												FLAGAPP	
												FLAGDKTR 1	* Specialist evaluation requested regarding fractured hip and chronic hip pain
194	Orthopedics	49 50 52	2 3 1	Y N N						FLG	00	EVALFORM 1 2	This evaluation must be completed by an orthopedic specialist if fracture occurred within the last year, otherwise it may be completed by the primary physician. * Condition reported: fracture of hip -Diagnosis: -Affected side: -Date of fracture:

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2 Hip

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: - Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable

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2 Hip

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* fracture of hip - evaluation by a specialist has been requested
624	Orthopedics	49 2 50 3 52 1	Y Y Y						FLG	00	EVALFORM 1 2	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician. * Condition reported: Fractured hip with chronic hip pain and hip reconstruction or replacement -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment:

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2 Hip

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding fractured hip with hip reconstruction or replacement with chronic hip pain
625	Orthopedics	49 2	N						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if surgery occurred

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2 Hip

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
		50	3	N								EVALFORM	within the last year, otherwise it may be completed by the primary physician.
		52	1	Y									2 * Condition reported: Hip reconstruction or replacement -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months:

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2 Hip

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Condition reported: hip reconstruction or replacement - evaluation by a specialist requested.

(3) Skull

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
190	Orthopedics	49 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Condition Reported: Skull fracture -Diagnosis: -Date of fracture: -Etiology: -Symptoms: -Frequency of symptoms:

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3 Skull

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Severity: -Neurological involvement: -Date of resolution: -Treatment (incl. retained hardware if applicable): -Current status: -Specific requirements for follow-up over next three years: -Attach: -copy of discharge summary if hospitalized -copies of all pertinent diagnostic test reports.

(*4*) *Pelvis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
193	Orthopedics	49 4	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: fracture of pelvis -Diagnosis: -Site: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement:

4 Pelvis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable

 # 50 Do you have or have you ever been medically treated or had surgery for:

(*1*) *Chronic or recurrent neck or back pain (excluding arthritis)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
199	Orthopedics	50 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Back and/or neck pain -Diagnosis: - Location:

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1 Chronic or recurrent neck or back pain (excluding arthritis)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-History of radiculopathy: -Any current radiculopathy: -Etiology: -# of episodes: -Date(s) of onset: -Date(s) of resolution: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Treatment: -Need for brace or orthotic device: If yes, describe: -name of device: -device care required: -need for replacement over the next 3 years: -Current status: -Restrictions and ADL limitations: - Number of contacts (e.g. visits and telephone contacts) with patient for this condition in the last 12 months: -Assessment of need for surgery over next three years: -Specific requirements for follow-up over next three years: -Attach: plan for self-management of pain

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1 Chronic or recurrent neck or back pain (excluding arthritis)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	copies of all pertinent diagnostic test reports (Do not send films)

(*2*) *Scoliosis or kyphosis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
652	Orthopedics	50 2	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2
												* Condition reported: Scoliosis or Kyphosis
												-Diagnosis:
												-Date of diagnosis:
												-Location:
												-Etiology:
												-Degree of curvature:
												-Severity:
												-Symptoms:
												-Frequency of symptoms:
												-Treatment:
												-Date and type of surgery if applicable:
												-Need for physical therapy:
												-Need for Brace or other orthotic device:
												-If yes: -name of device:
												-Care requirements of device:
												-Need for replacement over next 3 years:

2 Scoliosis or kyphosis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Current status: -Limitation or restriction of ADLs: -Specific requirements for follow-up over next three years: Attach: copies of all pertinent diagnostic test and operative reports.

(*3*) *Chronic hip pain*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
654	Orthopedics	49 2	N						FLG	00	FLAGAPP	
		50 3	Y								FLAGDKTR	2 * Condition reported: Chronic hip pain -Diagnosis: -Affected side: -Etiology: -Date of onset: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device:
		52 1	N									

3 Chronic hip pain

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
												FLAGDKTR	-Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports.
648	Orthopedics	49 50 52	2 3 1	Y N Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if the surgery has been in the last year, otherwise this form may be completed by the primary physician. 2 * Condition reported: Fractured hip and hip reconstruction or replacement -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity:

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3 Chronic hip pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Neurological involvement: -Treatment: -Date of treatment/surgery: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device: -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization -Copy of operative report Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding fractured hip and hip reconstruction or

3 Chronic hip pain

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text	
												FLAGDKTR		replacement
647	Orthopedics	49	2	Y						FLG	00	EVALFORM	1	This evaluation must be completed by an orthopedic specialist if the fracture occurred in the last year, otherwise it may be completed by the primary physician.
		50	3	Y									2	* Condition reported: fracture of hip and chronic hip pain -Diagnosis: -Affected side: -Date of fracture: -Etiology: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Treatment (incl. specific surgical procedure performed, if applicable): -Number of contacts (e.g. visits and telephone contacts) with patient for this condition in the last 12 months: -Current status: -Restrictions and ADL limitations: -Specific requirements for follow-up over next three years: -Attach: copies of all pertinent diagnostic test reports (Do not send films)
		52	1	N										

3 Chronic hip pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding fractured hip and chronic hip pain
683	Orthopedics	49 2 50 3 52 1	N Y Y						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if fracture occurred within the last year, otherwise it may be completed by the primary physician.
											2	* Condition reported: Chronic hip pain and hip reconstruction or replacement -Diagnosis: -Affected side: -Etiology: -Date of onset: -Date of resolution: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Surgical procedure: -Date of treatment/surgery: -Limitations/ADL restrictions:

3 Chronic hip pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization. -Copy of operative report. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding hip reconstruction or replacement with chronic hip pain.
625	Orthopedics	49 2 50 3 52 1	N N Y						FLG	00	EVALFORM 1 2	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician. * Condition reported: Hip reconstruction or replacement

3 Chronic hip pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years:

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3 Chronic hip pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Condition reported: hip reconstruction or replacement - evaluation by a specialist requested.
624	Orthopedics	49 2 50 3 52 1	Y Y Y						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician.
											2	* Condition reported: Fractured hip with chronic hip pain and hip reconstruction or replacement -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms:

3 Chronic hip pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Severity: -Neurological involvement: -Treatment: -Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?

3 Chronic hip pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding fractured hip with hip reconstruction or replacement with chronic hip pain
194	Orthopedics	49 2 50 3 52 1	Y N N						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if fracture occurred within the last year, otherwise it may be completed by the primary physician. 2 * Condition reported: fracture of hip -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device:

3 Chronic hip pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: - Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* fracture of hip - evaluation by a specialist has been requested

(*4*) *Chronic ankle pain (excluding uncomplicated ankle strains or sprains)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
655	Orthopedics	50 4	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Condition reported: Chronic ankle pain -Diagnosis: -Location: -Etiology:

4 Chronic ankle pain (excluding uncomplicated ankle strains or sprains)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-# of episodes: -Date(s) of onset: -Date(s) of resolution: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Treatment: -Need for brace or orthotic device: If yes, describe: -name of device: -device care required: -need for replacement over the next 3 years: -Current status: -Restrictions and ADL limitations: -Number of contacts (e.g. visits and telephone contacts) with patient for this condition in the last 12 months: -Assessment of need for surgery over next three years: -Specific requirements for follow-up over next three years: -Attach: plan for self-management of pain copies of all pertinent diagnostic test reports (Do not send films)

(5) Chronic knee pain

Rule #	Group	Ans	Sex	Timeframe	Mod	Insert # and Text

5 Chronic knee pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
626	Orthopedics	50 5 52 2	N Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician. 2 *Condition(s) reported: knee arthroscopy, ligament repair, reconstruction or replacement -Diagnosis: -Date of onset: -Location: -Etiology: -Symptoms: -Severity: -Treatments (include surgeries/dates , medication, other treatments) -Date of resolution: -Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Assessment of need for surgery over next three years -Limitations/restrictions in ADL's: -Specific requirements for follow-up over next three years: Attach: -copies of all pertinent diagnostic test reports (do not send films) -copies of all pertinent operative

5 Chronic knee pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	reports Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding knee arthoscopy, ligament repair, reconstruction or replacement.
316	Orthopedics	50 5 52 2	Y Y						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician.
											2	*Condition(s) reported: Chronic knee pain and knee surgery, ligament repair, or arthroscopy -Diagnosis: -Date of onset: -Location: -Etiology: -Symptoms: -Severity: -Treatments (include surgeries/dates, medication, other treatments) -Date of resolution: -Current status: -Number of times (e.g. visits and telephone contacts) patient

5 Chronic knee pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	contacted/sought treatment for this condition in the last 12 months: -Assessment of need for surgery over next three years -Limitations/restrictions in ADL's: -Specific requirements for follow-up over next three years: Attach: -copies of all pertinent diagnostic test reports (do not send films) -copies of all pertinent operative reports Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Condition(s) Reported: knee pain and knee surgery or arthroscopy - An evaluation by a specialist has been requested
195	Orthopedics	50 5	Y						FLG	00	FLAGAPP	
		52 2	N								FLAGDKTR 2	* Condition Reported: Chronic knee pain - Diagnosis: - Location: -Etiology: -# of episodes: -Date(s) of onset:

5 Chronic knee pain

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Date(s) of resolution: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Treatment: -Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Restrictions and ADL limitations: -Assessment of need for surgery over next three years: -Specific requirements for follow-up over next three years: -Attach: -plan for self-management of pain -copies of all pertinent diagnostic test reports (Do not send films) -copies of any pertinent operative reports

 # 51 Other than for arthritis or bursitis, have you been medically or surgically treated for:

(1) Chronic shoulder pain, dislocation or rotator cuff injury

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
604	Orthopedics	51 1	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist.
		51 2	N									2

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1 Chronic shoulder pain, dislocation or rotator cuff injury

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	* Condition Reported: Chronic shoulder pain, dislocated shoulder, or rotator cuff injury. -Diagnosis: -Affected shoulder: -Date of onset: -Number of episodes: -Date of last episode: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years:

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1 Chronic shoulder pain, dislocation or rotator cuff injury

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, PT, OT if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding chronic shoulder pain, dislocated shoulder, or rotator cuff injury
668	Orthopedics	51 1 51 2	N Y						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician.
											2	* Condition Reported: Shoulder arthroscopy, ligament repair, reconstruction or replacement -Diagnosis: -Affected shoulder: -Date of onset: -Number of episodes: -Date of last episode: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms:

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1 Chronic shoulder pain, dislocation or rotator cuff injury

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, PT, OT if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation has been requested for shoulder arthroscopy, ligament repair, reconstruction or replacement
627	Orthopedics	51 1 51 2	Y Y						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be

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1 Chronic shoulder pain, dislocation or rotator cuff injury

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	completed by the primary physician.
												2
												* Condition Reported: Chronic shoulder pain, dislocated shoulder, or rotator cuff injury with shoulder arthroscopy, ligament repair, reconstruction or replacement
												-Diagnosis:
												-Affected shoulder:
												-Date of onset:
												-Number of episodes:
												-Date of last episode:
												-Date of resolution:
												-Etiology:
												-Symptoms:
												-Frequency of symptoms:
												-Severity:
												-Treatment history:
												-Current treatment:
												-Limitations/ADL restrictions:
												-Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months:
												-Current status:
												-Likelihood of exacerbation over next 3 years:

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1 Chronic shoulder pain, dislocation or rotator cuff injury

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Specific requirements for follow up for the next 3 years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, PT, OT if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Chronic shoulder pain, dislocated shoulder, or rotator cuff injury with shoulder arthroscopy, ligament repair, reconstruction or replacement - evaluation by a specialist requested.

(*2*) *Shoulder arthroscopy, ligament repair, reconstruction or replacement*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
668	Orthopedics	51 1	N						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician.
		51 2	Y								2	* Condition Reported: Shoulder arthroscopy, ligament repair, reconstruction or replacement -Diagnosis: -Affected shoulder: -Date of onset: -Number of episodes:

2 Shoulder arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Date of last episode: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, PT, OT if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?

2 Shoulder arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation has been requested for shoulder arthroscopy, ligament repair, reconstruction or replacement
627	Orthopedics	51 1 51 2	Y Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician. 2 * Condition Reported: Chronic shoulder pain, dislocated shoulder, or rotator cuff injury with shoulder arthroscopy, ligament repair, reconstruction or replacement -Diagnosis: -Affected shoulder: -Date of onset: -Number of episodes: -Date of last episode: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient

2 Shoulder arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, PT, OT if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Chronic shoulder pain, dislocated shoulder, or rotator cuff injury with shoulder arthroscopy, ligament repair, reconstruction or replacement - evaluation by a specialist requested.
604	Orthopedics	51 1 51 2	Y N						FLG	00	EVALFORM 1 2	This evaluation must be completed by an orthopedic specialist. * Condition Reported: Chronic shoulder pain, dislocated shoulder, or rotator cuff injury. -Diagnosis: -Affected shoulder: -Date of onset:

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2 Shoulder arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Number of episodes: -Date of last episode: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, PT, OT if applicable -Copy of operative report, if applicable Were the above responses based on (please check one):

2 Shoulder arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding chronic shoulder pain, dislocated shoulder, or rotator cuff injury

 # 52 Have you ever had:

(*1*) *Hip reconstruction or replacement*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
194	Orthopedics	49 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if fracture occurred within the last year, otherwise it may be completed by the primary physician. 2 * Condition reported: fracture of hip -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment:
		50 3	N									
		52 1	N									

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: - Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* fracture of hip - evaluation by a specialist has been requested
625	Orthopedics	49 2	N						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if surgery occurred

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
		50	3	N								EVALFORM	within the last year, otherwise it may be completed by the primary physician.
		52	1	Y									2 * Condition reported: Hip reconstruction or replacement -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months:

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
												EVALFORM	-Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
												FLAGAPP	
												FLAGDKTR 1	* Condition reported: hip reconstruction or replacement - evaluation by a specialist requested.
624	Orthopedics	49 50 52	2 3 1	Y Y Y						FLG	00	EVALFORM 1 2	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician. * Condition reported: Fractured hip with chronic hip pain and hip reconstruction or replacement -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology:

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable Were the above responses based on (please

1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding fractured hip with hip reconstruction or replacement with chronic hip pain
683	Orthopedics	49 2 50 3 52 1	N Y Y						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if fracture occurred within the last year, otherwise it may be completed by the primary physician.
											2	* Condition reported: Chronic hip pain and hip reconstruction or replacement -Diagnosis: -Affected side: -Etiology: -Date of onset: -Date of resolution: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Surgical procedure: -Date of treatment/surgery: -Limitations/ADL restrictions:

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms		Insert # and Text
											EVALFORM		-Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization. -Copy of operative report. Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP		
											FLAGDKTR	1	* Specialist evaluation requested regarding hip reconstruction or replacement with chronic hip pain.
647	Orthopedics	49 2 50 3 52 1	Y Y N						FLG	00	EVALFORM	1 2	This evaluation must be completed by an orthopedic specialist if the fracture occurred in the last year, otherwise it may be completed by the primary physician. * Condition reported: fracture of hip and chronic hip pain

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Diagnosis: -Affected side: -Date of fracture: -Etiology: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Treatment (incl. specific surgical procedure performed, if applicable): -Number of contacts (e.g. visits and telephone contacts) with patient for this condition in the last 12 months: -Current status: -Restrictions and ADL limitations: -Specific requirements for follow-up over next three years: -Attach: copies of all pertinent diagnostic test reports (Do not send films) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding fractured hip and chronic hip pain

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
648	Orthopedics	49	2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if the surgery has been in the last year, otherwise this form may be completed by the primary physician. 2 * Condition reported: Fractured hip and hip reconstruction or replacement -Diagnosis: -Affected side: -Date of fracture: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment/surgery: -Surgical procedure: -Limitations/ADL restrictions: -Need for brace or other orthotic device: -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years:
		50	3	N									
		52	1	Y									

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization -Copy of operative report Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding fractured hip and hip reconstruction or replacement
654	Orthopedics	49 2 50 3 52 1	N Y N						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Condition reported: Chronic hip pain -Diagnosis: -Affected side: -Etiology: -Date of onset: -Symptoms:

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1 Hip reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Frequency of symptoms: -Severity: -Neurological involvement: -Treatment: -Date of treatment: -Limitations/ADL restrictions: -Need for brace or other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: -Copy of all pertinent diagnostic test reports.

(*2*) *Knee arthroscopy, ligament repair, reconstruction or replacement*

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text	
626	Orthopedics	50	5	N						FLG	00	EVALFORM	1	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician.
		52	2	Y									2	*Condition(s) reported: knee arthroscopy,

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2 Knee arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	ligament repair, reconstruction or replacement -Diagnosis: -Date of onset: -Location: -Etiology: -Symptoms: -Severity: -Treatments (include surgeries/dates , medication, other treatments) -Date of resolution: -Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Assessment of need for surgery over next three years -Limitations/restrictions in ADL's: -Specific requirements for follow-up over next three years: Attach: -copies of all pertinent diagnostic test reports (do not send films) -copies of all pertinent operative reports Were the above responses based on (please check one): ___ An historical evaluation?

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2 Knee arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
												EVALFORM	___ A current evaluation?
												FLAGAPP	
												FLAGDKTR	1 * Specialist evaluation requested regarding knee arthoscopy, ligament repair, reconstruction or replacement.
195	Orthopedics	50	5	Y						FLG	00	FLAGAPP	
		52	2	N								FLAGDKTR	2 * Condition Reported: Chronic knee pain - Diagnosis: - Location: -Etiology: -# of episodes: -Date(s) of onset: -Date(s) of resolution: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Treatment: -Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Restrictions and ADL limitations: -Assessment of need for surgery over next three years:

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2 Knee arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Specific requirements for follow-up over next three years: -Attach: -plan for self-management of pain -copies of all pertinent diagnostic test reports (Do not send films) -copies of any pertinent operative reports
316	Orthopedics	50 5 52 2	Y Y						FLG	00	EVALFORM	1 This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician. 2 *Condition(s) reported: Chronic knee pain and knee surgery, ligament repair, or arthroscopy -Diagnosis: -Date of onset: -Location: -Etiology: -Symptoms: -Severity: -Treatments (include surgeries/dates, medication, other treatments) -Date of resolution: -Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months:

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2 Knee arthroscopy, ligament repair, reconstruction or replacement

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Assessment of need for surgery over next three years -Limitations/restrictions in ADL's: -Specific requirements for follow-up over next three years: Attach: -copies of all pertinent diagnostic test reports (do not send films) -copies of all pertinent operative reports Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Condition(s) Reported: knee pain and knee surgery or arthroscopy - An evaluation by a specialist has been requested

(*3*) *Orthopedic hardware (pins, plates, rods, screws, etc.) left in place*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
622	Orthopedics	52 3	Y						FLG	00	EVALFORM 1	This evaluation must be completed by an orthopedic specialist if surgery occurred within the last year, otherwise it may be completed by the primary physician.
											2	*Condition Reported: Orthopedic hardware (pins, plates, rods, or screws) left in place. -Surgery performed and date: -Diagnosis and reason for surgery:

3 Orthopedic hardware (pins, plates, rods, screws, etc.) left in place

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Specify hardware retained/location: -Need for removal within the next three years: -Limitations/restrictions: -Specific requirements for follow-up within the next three years: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	*Orthopedic hardware left in place - evaluation by an orthopedic specialist has been requested

53 Do you have arthritis or bursitis that requires the use of prescription medication?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
214	Orthopedics	53 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Condition Reported: Pain in any joints, muscles, or bones which require medication -Diagnosis: -Date of onset: -Date of resolution: -Location: -Etiology:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copy of all pertinent diagnostic test reports. -Copy of discharge summary from hospitalization, if applicable -Copy of operative report, if applicable

 # 54 Do you have or have you ever had:

(*1*) *Repetitive motion injury/syndrome*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
208	Orthopedics	54 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Repetitive motion injury/syndrome

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1 Repetitive motion injury/syndrome

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Diagnosis: -Location/ Body part involved: -Etiology: -Dates of onset: -Date of resolution/control of symptoms: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Treatment (incl. oral or injectable medications): -Current status: -Need for braces, splints, other orthotic devices -Restrictions and ADL limitations: -Assessment of need for surgery over next three years: -Number of contacts (e.g. visits and telephone contacts) with patient for this condition in the last 12 months. -Specific requirements for follow-up over next three years: Attach: copies of all operative & diagnostic test reports (do not send films.)

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2 Carpal tunnel syndrome

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
209	Orthopedics	54 2	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Carpal tunnel syndrome -Diagnosis: -Etiology: -Extremity affected: -Dates of onset: -Date of resolution/control of symptoms: -Symptoms: -Severity of symptoms: -Frequency of symptoms: -Treatment (incl. oral or injectable medications): -Current status: -Need for braces, splints, other orthotic devices -Restrictions and ADL limitations: -Assessment of need for surgery over next three years: -Number of contacts (e.g. visits and telephone contacts(with patient for this condition in the last 12 months. -Specific requirements for follow-up over next three years: Attach: copies of all operative & diagnostic test reports (do not send films.)

2 Carpal tunnel syndrome

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	

 # 55 Do you currently have painful bunions?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
213	Orthopedics	55 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Painful bunion(s) -Location/ which foot: -Date(s) of onset: -Name of surgery (if applicable): -Date performed: -Date of resolution/control: -Symptoms: -Frequency of symptoms: -Severity of symptoms: -Treatment: -Medications: -Injections: -Need for other orthotic device -If yes: -name of device: -Care requirements of device: -Need for replacement over next 3 years: -Restrictions and ADL limitations:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Current status: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Assessment of need for surgery over next three years: -Specific requirements for follow-up over next three years: -Attach: -Plan for self-management of pain -Copy of all pertinent diagnostic test reports. -Copy of operative report, if applicable

 # 56 Within the last 5 years, have you had or been treated for any acute or chronic joint, muscle or bone condition or surgery not listed in items 49-55?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
215	Orthopedics	56 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Unspecified joint, muscle or bone condition or surgery -Diagnosis: -Etiology: -Location: -Date of onset: -Date of resolution: -Symptoms: -Severity of symptoms:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Frequency of symptoms: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: copies of all pertinent diagnostic test reports

 # 57 Do you have or have you ever had:

(*1*) *Fibromyalgia*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
217	Rheumatology	57 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Fibromyalgia -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms:

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1 Fibromyalgia

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copies of pertinent diagnostic test reports

(*2*) *Ankylosing spondylitis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
220	Rheumatology	57 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a rheumatology specialist or the primary physician. 2 * Condition reported: Ankylosing Spondylitis -Diagnosis: -Date of onset: -Date of resolution: -Etiology:

2 Ankylosing spondylitis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copies of pertinent diagnostic test reports Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding ankylosing spondylitis.

(*3*) *Rheumatoid arthritis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text

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3 Rheumatoid arthritis

Rule #	Group	Question & Sub Quest#		Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
223	Rheumatology	57	3	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a rheumatology specialist. 2 * Condition reported: Rheumatoid Arthritis (adult onset) -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copies of pertinent diagnostic test reports

3 Rheumatoid arthritis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding rheumatoid arthritis.

(*4*) *Juvenile rheumatoid arthritis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
224	Rheumatology	57 4	Y						FLG	00	EVALFORM 1	This evaluation must be completed by a rheumatology specialist or primary physician.
											2	* Condition reported: Juvenile Rheumatoid Arthritis -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought

4 Juvenile rheumatoid arthritis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copies of pertinent diagnostic test reports Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding juvenile rheumatoid arthritis.

 # 58 Do you currently have:

(*1*) *Iron deficiency anemia*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
233	Hematology	58 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR 2	* Iron deficiency anemia If condition is within the past year, please include: -Date of onset: -Copy of results of Fe level, TIBC and/or ferritin level tests:

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1 Iron deficiency anemia

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Results of stool for occult blood X 3 (if applicable): -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (including medications): -Current status: -Specific requirements for follow-up over next three years: Attach: Other pertinent laboratory/diagnostic tests (i.e., reticulocyte count, CBC, MCV, etc.): For diagnosis greater than one year, the initial evaluation must have: Total iron binding capacity (TIBC), CBC, ferritin level (if applicable) -Date of onset: -Date of resolution: - Etiology: - Treatment (including medications): -Current status: -Specific requirements for follow-up over next three years:

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1 Iron deficiency anemia

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	

(2) A low platelet count (thrombocytopenia)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
236	Hematology	58 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a hematology specialist. 2 * Condition reported: low platelet count (thrombocytopenia) -Diagnosis: -Date of onset: -Date of resolution: -Symptoms: -Frequency of symptoms: -Severity: -Etiology: -Complications: -Limitations/restrictions of ADL: -Treatment: -Specific requirements for follow-up over next three years: -Attach copy of results of pertinent laboratory tests (CBC with differential, PT, PTT) and diagnostic procedures. Were the above responses based on (please check one): ___ An historical evaluation?

2 A low platelet count (thrombocytopenia)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding low platelet count.

(*3*) *A missing spleen (due to surgery)*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
237	Hematology	58 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Removal of spleen -Reason for removal: -Date of surgery: -Current status (incl. sequelae): -Specific requirements for follow-up over next three years: Attach: copies of all pertinent laboratory, operative and diagnostic test reports.

 # 59 Do you have any other blood, immune system, connective tissue or collagen condition not listed in items 57-58?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
230	Rheumatology	59 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: unspecified blood, immune system, or connective tissue/collagen disorder -Diagnosis: -Date of onset: -Date of resolution:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: -Copy of any pertinent diagnostic test reports -Copy of hospital discharge summaries (if applicable)

60 Do you have diabetes?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
245	Endocrinology	60 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: Diabetes -See enclosed special evaluation form
											FORM-DIAB	

61 Do you have or have you ever been treated for gout?

Rule #	Group	Ans	Sex	Timeframe	Mod	Insert # and Text

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
247	Endocrinology	61 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Gout -Date of diagnosis: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history with dates: -Date of last treatment: -Current status: -Current medication(s) with dose: -Diet restrictions: -Other limitations or restrictions: -Specific requirements for follow-up over next three years: -Attach: - copy of results of current uric acid level, liver function tests - self-management plan

 # 62 Do you have or have you ever had:

(*1*) *A thyroid goiter*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
252	Endocrinology	62 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Goiter

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1 A thyroid goiter

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Diagnosis -etiology: -Dates of diagnosis: -Date ofresolution/control: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications, radioactive therapy with dates): -Current status: -Full physical description of the gland: -Specific requirements for follow-up over next three years: -Attach: - copy of results of TSH level, T4 level - discharge summaries for all related hospitalizations - operative reports for all related surgeries - biopsy reports for all nodules - anti thyroid antibodies if appropriate - results of ultrasound or thyroid scan if applicable

(2) A thyroid nodule

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
254	Endocrinology	62 2	Y						FLG	00	FLAGAPP	

2 A thyroid nodule

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	2 * Thyroid nodule -Diagnosis: -Etiology: -Date of diagnosis: -Date of resolution/control: -Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications, radioactive therapy with dates): -Current status: -Full physical description of the gland: -Specific requirements for follow-up over next three years: -Attach: - copy of results of TSH level, T4 level - discharge summaries for all related hospitalizations - operative reports for all related surgeries - biopsy reports for all nodules - anti thyroid antibodies if appropriate - results of ultrasound or thyroid scan if applicable

(3) An overactive thyroid (hyperthyroidism)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text

3 An overactive thyroid (hyperthyroidism)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
251	Endocrinology	62 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Overactive thyroid (hyperthyroidism) -Diagnosis/etiology, -Dates of diagnosis and resolution/control -Symptoms and severity -Treatment (incl. medications, radioactive therapy with dates): -Current status -Specific requirements for follow-up over next three years -Attach: - copy of results of TSH level, T4 level - discharge summaries for all related hospitalizations - operative reports for all related surgeries - biopsy reports for all nodules - anti thyroid antibodies if appropriate

(4) An underactive thyroid (hypothyroidism)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
258	Endocrinology	62 4	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Underactive thyroid (hypothyroidism) -Diagnosis: -Etiology: -Date of diagnosis: -Date of resolution/control:

4 An underactive thyroid (hypothyroidism)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Symptoms: -Frequency of symptoms: -Severity: -Full physical description of the gland: -Treatment (incl. medications, radioactive therapy with dates): -Current status: -Specific requirements for follow-up over next three years: -Attach: - copy of results of TSH level, T4 level - discharge summaries for all related hospitalizations - operative reports for all related surgeries - biopsy reports for all nodules - anti thyroid antibodies if appropriate

(*5*) *Other thyroid disease*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
600	Endocrinology	62 5	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Unspecified thyroid disease -Diagnosis: -Date of onset: -Etiology: -Symptoms: -Frequency of symptoms:

5 Other thyroid disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Severity: -Treatment, to include: -Medications and date of last medication or dosage adjustment -Surgery, or radioactive therapy, with dates -Current status: -Specific requirements for follow up over the next 3 years: -Attach: -Copy of results of TSH level, T4 level laboratory reports. -Copy of any related pathology report(s) -Copy of any other pertinent laboratory or diagnostic tests.

 # 63 Do you have or have you ever had a disease of the pituitary gland

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
261	Endocrinology	63 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: disease of the pituitary gland -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: Copy of all pertinent laboratory and diagnostic test reports.

64 Do you have or have you ever had any other condition of the endocrine system not listed in items 60 - 63?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
264	Endocrinology	64 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Unspecified condition(s) of endocrine glands/system -Diagnosis: -Etiology: -Date of diagnosis: -Date of resolution/control:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Symptoms: -Frequency of symptoms: -Severity: -Treatment (incl. medications, radioactive therapy with dates): -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Specific requirements for follow-up over next three years: -Attach: copy of results of pertinent laboratory or diagnostic tests

 # 65 Did you have a blood transfusion before July 1992?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
656	Infectious Disease	65 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Blood transfusion before July, 1992. - Reason for transfusion: - Date of transfusion: - Complicatons: - Attach test results for hepatitis panels (A, B, C)

 # 66 Have you ever been exposed to Hepatitis B or C virus by injury, accidental needlestick, injection of drugs (even once), or because your

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Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
707	Infectious Disease	66 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Exposed to the Hepatitis B or C virus by injury, accidental needlestick, injection of drugs, or during birth to mother with Hepatitis C -Date of exposure -Treatment -Current Symptoms - Attach most recent pertinent laboratory studies to include hepatic and hepatitis panel

mother had Hepatitis B or C virus when you where born?

 # 67 Do you have or have you ever had (this does NOT refer to immunizations):

(*1*) *Hepatitis A virus*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
658	Infectious Disease	67 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 *Have or had Hepatitis A -Date of exposure: -Date symptoms resolved: Attach: Most recent pertinent laboratory studies

(*2*) *Hepatitis B virus*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
659	Infectious Disease	67 2	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Have or have had Hepatitis B

2 Hepatitis B virus

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Date of exposure: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Current status: -Limitations: -Requirements for the next 3 years: *Attach: -most recent pertinent laboratory studies to include: -Liver function tests for all/new diagnoses. -Complete Hepatitis panel, to include Hepatitis BsAg, Hepatitis Bc Ab, Hepatitis BeAg, quantitative HBV DNA. -Liver function tests x 2 at least 6 months apart (second test should be done within last 12 months) for chronic carriers. -any other pertinent laboratory reports (e.g. hepatocellular carcinoma screening tests, serum alpha fetoprotein) as applicable. -any other diagnostic test reports (e. US, CT, & MRI) as applicable.

(*3*) *Hepatitis C virus*

Rule #	Group	Ans	Sex	Timeframe	Mod	Insert # and Text

3 Hepatitis C virus

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
660	Infectious Disease	67 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Have or have had Hepatitis C -Date of exposure: -Date of acute infection: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -History of relapse: -Treatment history: -Current treatment: -Current status: -Limitations: -Requirements for the next 3 years: Attach: -copy of most recent qualitative HCV RNA assays x2 at least 6 months apart. -copy of most recent liver function tests x2 at least 6 months apart -copy of liver biopsy report with interpretation, if done.

 # 68 Do you have or have you ever had:

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(1) *Chronic fatigue syndrome*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
267	Infectious Disease	68 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Chronic fatigue syndrome -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: copies of all pertinent laboratory and diagnostic test reports.

(*2*) *A positive skin test for tuberculosis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
268	Infectious Disease	68 2	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Positive skin test for tuberculosis See Special Evaluation Form
											FORM-TUBE	

(*3*) *Active tuberculosis disease of the lungs or other organs*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
269	Infectious Disease	68 3	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Tuberculosis (active disease of lungs or other organs) -Date of onset: -Treatment (include surgical and medical treatment) and duration: -Current status: -Specific recommendations for follow-up over next three years: -Attach copy of results of most recent chest x-ray, other diagonostic tests performed

(*4*) *Lyme disease*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
270	Infectious Disease	68 4	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Lyme disease -Dates of onset: -Date of resolution:

4 Lyme disease

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Symptoms: -Frequency of symptoms: -Severity: -Complications: -Current status: -Treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: Attach: copy of most recent Lyme titer

69 Other than a cold or the flu, do you currently have any other infectious or parasitic condition not listed in items 65-68?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
272	Infectious Disease	69 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Unspecified infection or parasitic condition (excluding colds or flu) -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Frequency of symptoms: -Severity: -Complications: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: Copy of all pertinent laboratory and diagnostic test reports.

70 Do you have severe or migraine headaches that require prescription medication?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
273	Neurology	70 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Severe or migraine headache, currently taking prescription medication -Diagnosis: -Date of diagnosis: -Etiology:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Symptoms (incl. transient neurological deficits and/or visual aura): -Severity of symptoms: -Frequency of symptoms: -Duration of symptoms: -Treatment (incl. medications, dose, route of administration): -Current status: -Extent of interference with daily activities: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Specific requirements for follow-up over next three years: -Attach: plan for self-management of headaches and discharge summary (if applicable) -Attach: copies of any pertinent diagnostic test reports.

71 Since age 15, have you ever had any seizures or convulsions?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
276	Neurology	71 0	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a neurology specialist. 2 * Seizure(s) after age 15 -Diagnosis:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Date of diagnosis: -Date of last seizure: -Type of seizure: -Etiology: -Symptoms with frequency and severity (including neurological deficits or aura): -Treatment history: -Current limitations and/or restrictions: -Current status: -Current treatment: -Medication(s) with dates initiated and completed (include therapeutic levels): -Follow-up recommendations for next 3 years: -Attach: Related surgery reports or statement from treating specialist describing procedure and resolution: : Pertinent diagnostic reports (EEG) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Condition Reported: Seizure(s) with onset after age 15 - evaluation by a specialist has been requested

 # 72 Have you ever had a stroke or stroke-like symptoms?

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Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
277	Neurology	72 0	Y						PND	00	EVALFORM	1 This evaluation must be completed by a neurology or neurosurgical specialist. 2 * Stroke or stroke-like symptoms -Diagnosis: -Date of event: -Symptoms: -Etiology: -Treatment (include current medications; attach copy of discharge summary if hospitalized): -Current status (incl. residual limitations or retrictions of ADLs): -Smoking history: -Specific requirements for follow-up over next three years: -Attach copy of results of stress test (Bruce protocol), most recent ECG with interpretation and other pertinent laborator tests and diagnostic procedures: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	1 * stroke or stroke-like symptoms

 # 73 Do you have:

(*1*) *Cerebral Palsy*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text

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1 Cerebral Palsy

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
661	Neurology	73 1	Y						FLG	00	EVALFORM	1 This evaluation must be completed by the treating specialist (MD). 2 * Cerebral palsy -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: copies of all pertinent laboratory and diagnostic test reports. Were the above responses based on (please check one):

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1 Cerebral Palsy

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR	1 * Specialist evaluation requested regarding Cerebral Palsy.

(*2*) *Multiple Sclerosis*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
281	Neurology	73 2	Y						PND	00	EVALFORM	1 This evaluation must be completed by the treating specialist (MD). 2 * Multiple Sclerosis -Date of diagnosis: -Specific Type of MS: -Exacerbation symptoms with frequency and severity (include dates of episodes within past two years): -Current status to include symptoms between exacerbations: -Current physical limitations: -Treatment history with dates: -Treatment (OT,PT, etc): -Status of assistive devices (if applicable):

2 Multiple Sclerosis

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Medication(s) with dates initiated and completed: -Follow-up recommendations for the next 3 years: Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											PND	* Multiple Sclerosis

74 Do you have or have you ever had any other neurological or nervous system condition or surgery not listed in items 70-73?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
282	Neurology	74 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Unspecified neurological or nervous system condition or surgery -Diagnosis: -Date of onset: -Date of resolution: -Etiology: -Symptoms: -Frequency of symptoms: -Severity: -Neurological examination findings:

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	-Treatment history: -Current treatment: -Limitations/ADL restrictions: -Number of times (e.g. visits and telephone contacts) patient contacted/sought treatment for this condition in the last 12 months: -Current status: -Likelihood of exacerbation over next 3 years: -Specific requirements for follow up for the next 3 years: Attach: copy of results of pertinent laboratory tests or diagnostic procedures performed

 # 75 Do you have or have you ever had:

(*1*) *Leukemia or lymphoma*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
283	Cancer	75 1	Y						FLG	00	EVALFORM	1 This evaluation must be completed by an oncology (cancer) specialist. 2 * Condition reported: Leukemia or lymphoma -Diagnosis, stage -Date of diagnosis -Treatment (incl. medication[s], radiation therapy, any surgical procedure, and date of completion for each of the above) -Current status, incl. number of years cancer-free

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1 Leukemia or lymphoma

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	-Likelihood of recurrence -Specific requirements for follow-up over the next three years -Attach: -copy of results of most recent bone scan to rule out metastasis -biopsy reports -most recent pertinent laboratory test(s) and diagnostic procedure(s) Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding Leukemia or lymphoma.

(*2*) *Any other type of cancer or malignant tumor not previously noted on this form*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
292	Cancer	75 2	Y						FLG	00	EVALFORM	1 This evaluation must be completed by a hematologist, dermatologist or oncologist (cancer specialist). 2 *Condition Reported: Unspecified cancer or malignant tumor -Diagnosis, stage -Date of diagnosis -Tumor type -Number of positive lymph nodes, if known -Treatment to include primary treatment,

2 Any other type of cancer or malignant tumor not previously noted on this form

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	eg., surgery and adjuvant treatment eg., radiation, chemotherapy, hormone therapy. Include date treatment was completed for each. -History of any recurrence -Current status to include number of years cancer-free -Specific requirements for follow-up over the next three years -Attach: -copy of results of most recent bone scan, if applicable, to rule-out metastasis -copy of biopsy/surgical reports -most recent pertinent laboratory test(s) and diagnostic procedure(s) -discharge summaries of all related hospitalizations Were the above responses based on (please check one): ___ An historical evaluation? ___ A current evaluation?
											FLAGAPP	
											FLAGDKTR 1	* Specialist evaluation requested regarding other type of cancer or malignant tumor.

 # 76 Are you:

(1) Recovering from alcohol abuse/dependence? If YES, give start date of recovery.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
304	Psychology	76 1	Y		< 3 yrs	0	37	36	DFR	UR	DEFERNOKIT	

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1 Recovering from alcohol abuse/dependence? If YES, give start date of recovery.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
307	Psychology	76 1	Y		> 3 yrs	38			FLG	00	ALCSUB	
											FLAGAPP	
											FLAGDKTR	1 * been in recovering from alcohol abuse for over 3 years. See enclosed special letter.
											PRSSTMT	1 * been in recovering from alcohol abuse for over 3 years

(2) Recovering from substance abuse/dependence? If YES, give start date of recovery.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
309	Psychology	76 2	Y		< 5 yrs	0	61	60	DFR	UR	DEFERNOKIT	
308	Psychology	76 2	Y		> 5 yrs	62			FLG	00	ALCSUB	
											FLAGAPP	
											FLAGDKTR	1 * been in recovering from substance abuse for over five years. See enclosed special letter.
											PRSSTMT	1 * been in recovering from substance abuse for over five years

 # 77 Have you ever had:

(1) Family counseling (such as related to marital issues)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
616	Psychology	77 1	Y						FLG	00	FLAGAPP	
											FLAGDKTR	1 * Family counseling - a personal statement has been requested.
											PRSSTMT	1 * received family counseling

(2) Support group counseling (such as for grief or divorce)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
618	Psychology	77 2	Y						FLG	00	FLAGAPP	

2 Support group counseling (such as for grief or divorce)

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	1 * Support group counseling - a personal statement has been requested.
											PRSSTMT	1 * received support group counseling

 # 78 Other than for academic guidance counseling only, have you ever had:

(1) Individual counseling or consultation with a psychiatrist, psychologist or mental health counselor. If YES, give date of last counseling session.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
294	Psychology	78 1	Y		<10 yr	0	121		FLG	00	EVALFORM	1 This evaluation must be completed by the treating psychiatrist, psychologist, or mental health counselor. 2 * Condition reported: Received psychiatric, psychological, or mental health counseling within the last 10 years. - See enclosed special evaluation form.
											FLAGAPP	
											FLAGDKTR	1 * Condition reported: Received psychiatric, psychological, or mental health counseling within the last 10 years. - An evaluation by a specialist has been requested.
											FORM-PPSY	
											PRSSTMT	1 * received mental health counseling/treatment
293	Psychology	78 1	Y		> 10 years	122			FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: received psychiatric, psychological, or mental health counseling over ten years ago -Individual counseling: approximate begin and end dates -Group counseling: approximate begin

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1 Individual counseling or consultation with a psychiatrist, psychologist or mental health counselor. If YES, give date of last counseling session.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	and end dates -Type of group: -DSM diagnosis, if given -Reason for counseling (include symptoms): -Medications used, if any -Current status
											PRSSTMT	1 * Received mental health counseling/treatment

(*2*) *Substance abuse or alcohol abuse counseling (other than awareness counseling or classes related to traffic citations). If YES, give date of last counseling session.*

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
295	Psychology	78 2	Y		< 10 yrs	0	121		FLG	00	EVALFORM	1 This evaluation must be completed by the treating psychiatrist, psychologist, or mental health counselor. 2 * Condition reported: Substance or alcohol abuse counseling within the last 10 years. - See enclosed special evaluation form.
											FLAGAPP	
											FLAGDKTR	1 * Condition reported: Substance or alcohol abuse counseling within the last 10 years. See enclosed evaluation form.
											FORM-PPSY	
											PRSSTMT	1 * have received counseling for alcohol and/or substance abuse
278	Psychology	78 2	Y		> 10yrs	122			FLG	00	FLAGAPP	
											FLAGDKTR	1 * Substance or alcohol abuse counseling over 10 years ago - a personal statement has been requested.

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2 Substance abuse or alcohol abuse counseling (other than awareness counseling or classes related to traffic citations). If YES, give date of last counseling session.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	2 * Condition reported: received substance abuse or alcohol counseling over ten years ago -Individual counseling: approximate begin and end dates -Group counseling: approximate begin and end dates -Type of group: -DSM diagnosis, if given -Reason for counseling (include symptoms): -Medications used, if any -Current status
											PRSSTMT	1 * have received counseling for alcohol and/or substance abuse

 # 79 Do you currently or have you ever used medication(s) for a mental health issue? If YES, give start date of medication.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
705	Psychology	79 0	Y		< 10yrs	0	121		FLG	00	EVALFORM	1 This evaluation must be completed by the prescribing physician. 2 * Condition reported: use of prescription medications for a mental health issue less than ten years ago -See enclosed special evaluation form
											FLAGAPP	
											FLAGDKTR	1 * Condition reported: Use of prescription medications for a mental health issue

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	within the last ten years - An evaluation by a specialist has been requested.
											FORM-PPSY	
											FORM-PSYCH	
											PRSSTMT	1 * use(d) psychotropic medication(s)
298	Psychology	79 0	Y		(c) >10 yr	122			FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Use of prescription medications for a mental health issue over ten years ago -Medication prescribed: -Dose: -Date initiated: -Duration of therapy/date discontinued: -Reason for prescription/diagnosis: -Reason for discontinuing medication: -Current status: -Specific requirements for follow-up over next three years
											PRSSTMT	1 * use(d) psychotropic medication(s)

80 Have you ever received in-patient psychiatric care? If YES, give date of last in-patient psychiatric care.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
310	Psychology	80 0	Y		> 5yrs	62			FLG	00	EVALFORM	1 This evaluation must be completed by the treating psychiatrist, psychologist or mental health counselor. 2 * Condition reported: hospitalized for psychiatric care over 5 years ago -See enclosed special evaluation form.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	
											FLAGAPP	
											FLAGDKTR	1 * Condition reported: hospitalized for psychiatric care over 5 years ago -See enclosed special evaluation form.
											FORM-PPSY	
											PRSSTMT	1 * was hospitalized for a mental health condition.
299	Psychology	80	0	Y	< 5yrs	0	61		PND	00	EVALFORM	1 This evaluation must be completed by the treating psychiatrist, psychologist or mental health counselor. 2 *Condition reported: in-patient psychiatric care within the last 5 yrs. -See enclosed special evaluation form.
											FORM-PPSY	
											PND	1 *Hospitalization for psychiatric care within the last 5 years.
											PRSSTMT	1 * was hospitalized for a mental health condition.

 # 81 Have you ever tried to harm yourself or attempted suicide? If YES, give date of incident.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
312	Psychology	81	0	Y	> 5 yrs	62			FLG	00	EVALFORM	1 This evaluation must be completed by the treating psychiatrist, psychologist or mental health counselor. 2 *Condition reported: tried to harm yourself or attempted suicide over 5 year ago.
											FLAGAPP	
											FLAGDKTR	1 * Condition reported: tried to harm yourself or attempted suicide over 5 years ago -See enclosed special evaluation form

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FORM-PPSY	
											PRSSTMT	1 * attempted suicide or attempted to harm yourself
311	Psychology	81	0	Y	< 5yrs	0	61		PND	00	EVALFORM	1 This evaluation must be completed by the treating psychiatrist, psychologist or mental health counselor. 2 *Condition reported: tried to harm yourself or attempted suicide within the last 5 years.
											FORM-PPSY	
											PND	1 *attempted suicide or tried to harm yourself.
											PRSSTMT	1 * attempted suicide or attempted to harm yourself

 # 82 Have you ever been diagnosed with, had symptoms of, or been treated for an eating disorder? If YES, give date of your most recent symptoms, treatments, or support group participation.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
303	Psychology	82	0	Y	(b) >3 yr	38			FLG	00	EVALFORM	1 This evaluation must be completed by the treating psychiatrist, psychologist or mental health counselor. 2 * Condition reported: treatment for an eating disorder over three years ago -See enclosed special evaluation form.
											FLAGAPP	
											FLAGDKTR	1 * Condition Reported: Treatment for an eating disorder over three years ago. - An evaluation by a specialist has been requested
											FORM-EAT	
											PRSSTMT	1 * treated for or have had symptoms of an eating disorder
302	Psychology	82	0	Y	(a) <3 yr	0	37	36	PND	00	EVALFORM	1 This evaluation must be completed by the treating psychiatrist, psychologist or mental health counselor. 2 * Condition Reported: History of an eating

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											EVALFORM	disorder within the last three years. - See the enclosed special evaluation form
											FORM-EAT	
											PND 1	* treatment for an eating disorder within the last three years
											PRSSTMT 1	* treated for or have had symptoms of an eating disorder

 # 83 Have you ever been diagnosed with, or had symptoms of ADD/ADHD? If YES, give date of diagnosis or date of last symptoms.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
702	Psychology	83 0	Y		> 10	122			FLG	00	FLAGAPP	
											FLAGDKTR 2	* Condition reported: Diagnosed with or had symptoms of ADD/ADHD over ten years ago. -DSM diagnosis, if given: -Medications used, if any (to include start and end dates): -Current status:
											PRSSTMT 1	* diagnosed with, or had symptoms of ADD/ADHD.
701	Psychology	83 0	Y		< 10 yrs	0	121		FLG	00	EVALFORM 1 2	This evaluation must be completed by the treating physician. *Condition reported: Been diagnosed or had symptoms of ADD/ADHD. - See enclosed special evaluation form.
											FLAGAPP	
											FLAGDKTR 1	* Condition Reported: Diagnosed and had symptoms of ADD/ADHD within the last ten years. - See enclosed special evaluation form.

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FORM-PPSY	
											FORM-PSYCH	
											PRSSTMT	1 *diagnosed with, or had symptoms of ADD/ADHD.

84 Are you currently using or have you ever used medication for ADD/ADHD?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
703	Psychology	84 0	Y						FLG	00	EVALFORM	1 This evaluation must be completed by the prescribing physician. 2 * Condition reported: Has used or is currently using medication for ADD/ADHD. - See enclosed special evaluation form.
											FLAGAPP	
											FLAGDKTR	1 * Currently using or has used medications for ADD/ADHD. See special evaluation form.
											FORM-PPSY	
											FORM-PSYCH	
											PRSSTMT	1 * currently using or has used medications for ADD/ADHD

85 Do you have or have you ever had any other mental health condition not listed in Items 76 -84?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
619	Psychology	85 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	1 * Condition Reported: Unspecified mental health condition - See enclosed special evaluation form
											FORM-PPSY	

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											PRSSTMT	1 * an unspecified mental health condition

86 Do you use a prosthesis or other assistive device, e.g., wheelchair , walker, cane, leg braces, hearing aid(s)?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
665	Activities of Daily Living	86 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Uses a prosthesis or other assistive device - Condition (diagnosis) necessitating use of assistive device: - Assistive device used: - Under what specific circumstances is the assistive device used? - When was the assistive device first used and how often is it needed? - What is the specific maintenance, and how often is maintenance required for the assistive device? - What is the likelihood the assistive device will need to be replaced during the next 2-3 years while in Peace Corps? NOTE-If the condition (diagnosis) necessitating the assistive device has not been previously reported, we may request further information.

87 Do you have any deficit in your hearing, vision or speech that might affect your ability to learn a foreign language?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
666	Activities of Daily Living	87 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition reported: Has a deficit in hearing, vision or speech that might interfere with work or ability to learn a

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	foreign language - Condition (diagnosis) that causes the deficit in hearing, vision or speech: - What is the specific deficit in hearing, vision or speech? - What is the severity of the deficit? - When was the deficit first diagnosed? - What is done to correct or modify the deficit? - What is the likelihood the deficit will progress the next 2-3 years during Peace Corps service? - Attach: pertinent recent test reports NOTE-If the condition (diagnosis) causing the deficit in the applicant's hearing, vision or speech has not been previously reported, we may request further information.

 # 88 Do you have or have been regarded as having any health related (physiological, emotional, or psychological), condition that significantly impairs any activity?

Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
704	Other	88 0	Y						FLG	00	FLAGAPP	
											FLAGDKTR	2 * Condition Reported: Other health related (physiological, emotional, or psychological) condition which impairs one or more of your activities. - Diagnosis: - Etiology: - Description of symptoms:

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Rule #	Group	Question & Sub Quest#	Ans	Sex	Timeframe	Beg Months	End Months	Defer Months	Health Status	Mod	Letters & Forms	Insert # and Text
											FLAGDKTR	- Frequency and duration of symptoms: - Activities which are impaired: - Treatment (including medications): - Outcome of treatment: - Any recommendations for continuation of treatment: - Coping skills to be used for this condition while serving as a Peace Corps volunteer: