

EATING DISORDERS QUESTIONNAIRE (continued)

10. Do you or your immediate family members (parents, siblings) have a history of any of the following associated conditions (circle all that apply)?

depression

suicidal thought/attempt

substance abuse (alcohol or drugs)

other psychiatric disorder

11. Do you have any other major health problems? No Yes

Details:

Additional Information (please use reverse side for additional space):

Date: _____

Insured's Signature: _____