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Arthritis Questionnaire

Claims Administrator:
Consociate•Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: ____________________

Employee name: ____________________

Dependent name (if condition is for dependent) ____________________

Age: ________ Height: ________ Weight: ________

1. Type of arthritis; actual diagnosis, if known (i.e. rheumatoid, osteoarthritis, gouty, psoriatic, Reiter's syndrome, etc) ____________________
2. Age at onset of disease: ________ Date first diagnosed: ________
3. Location of arthritis: ____________________

   Is there any disability, deformity or decrease in motion? Please explain. ________

   ____
4. Treatment-past ____________________

   current ____________________
5. Medication therapy (i.e. steroids, gold, anit-inflammatory drugs). Include name, dosage, frequency, length of treatment and anticipated duration ________

   ____

   ____

   ____

   ____

   ____

   ____

   Ever participated in any experimental drug program? Yes or No

   If yes, when? ________ Name of medication: ________

   For how long? ________ Through what facility? ________
6. Is there any history of work being missed due to this condition? Yes or No

   Please explain: ____________________

   ____
7. Any fluid aspiration from your joints or surgical replacement of joints? Yes or No

   If so, explain details, i.e. date, location, etc. ____________________

   ____

   Any need for future surgery? Yes or No Scheduled? Yes or No

Please be advised that you may be required to submit medical records.

Employee signature: ____________________ Date: ________