

# Cancer, Cyst, Tumor 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. Specific name (type), location and size, if known: \_\_\_\_\_

\_\_\_\_\_

2. When was condition first diagnosed: \_\_\_\_\_

\_\_\_\_\_

3. Surgery/treatment? Date and description. One or more times? \_\_\_\_\_

\_\_\_\_\_

4. Benign or malignant findings through pathology report? \_\_\_\_\_

5. Any metastasis? Yes or No If yes, where? \_\_\_\_\_

6. Has there been any Chemotherapy/Radiation performed at any time? Yes or No

If so, number of treatments? \_\_\_\_\_ When was the last one? \_\_\_\_\_

7. Are you taking any medications?

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. How often do you return for check-ups? \_\_\_\_\_ Date last seen and results: \_\_\_\_\_

9. Any complications/residuals? \_\_\_\_\_

10. Smoker? Yes or No Cigarettes/tobacco use per day? \_\_\_\_\_

If not currently using, how long ago did you quit? \_\_\_\_\_

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

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

