

Cholesterol 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. When was condition first diagnosed? _____

2. Please circle all that apply. Do you smoke, have high blood pressure, diabetes or a family history of coronary heart disease. Other medical conditions? _____

3. What problems or symptoms have been experienced with this condition? (i.e. chest pain, activity intolerance, etc.) _____

4. Date of last test and results for cholesterol, triglycerides, HDL, LDL and cholesterol/HDL ratio? These lab results MUST be provided. If unsure, please call your Doctor to ask. If you cannot provide these results, you must submit copies of the lab results from your Doctor. _____

5. What treatment was received and when? Include any surgery, hospital stays and medication with dosage and frequency: _____

6. How often does the person visit the Doctor's office or medical clinic for this condition
When was the last time and what was the result? _____

7. Have future tests, surgery or treatment been scheduled, prescribed or recommended?
Yes or No If yes, please explain: _____

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

Employee signature: _____ Date: _____

