

Digestive Disorder 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. What is the condition that has been diagnosed? Colitis (ulcerative or non-ulcerative)
Diverticulitis, Gastritis, Irritable bowel syndrome, Ulcer (specify which type), other?

2. What problems or symptoms have occurred? _____

3. Have any tests been done? Yes or No If yes, give name of test, date done
and results: _____

4. What treatment was received and when? Include and list all medications, with dosage
and frequency and hospitalizations and/or surgery(s) _____

5. Have future tests, treatments or surgery been recommended, prescribed or scheduled?
When? _____

6. Does this person have a colostomy? Yes or No Temporary or Permanent?

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

Employee signature: _____ Date: _____

