

Esophagus 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 specific medical condition that has been diagnosed? _____
_____ When did it begin? _____

2. Cause, if known: _____

3. What problems or symptoms have been experienced with this condition, and the last time they occurred? _____

4. What treatment was received and when? Include any surgery, hospital stays and dates

_____ Date _____

_____ Date _____

Medication	Dosage	Frequency	Current?	Date stopped
_____	_____	_____	Yes or No	_____
_____	_____	_____	Yes or No	_____
_____	_____	_____	Yes or No	_____

5. 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? _____

6. Have any endoscopies or biopsies been performed? Provide the date and results.

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

Employee signature: _____ Date: _____

