AGC HEALTH PLAN
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Female Disorders 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, i.e. endometriosis, abnormal pap, irregular bleeding, D&C, uterine fibroids, etc.? ____________________
2. Date of onset? __________ Date of diagnosis? __________
   Cause, if known: ____________________
3. Symptoms experienced: ____________________
4. Type of treatment received and when? ____________________
5. Please list ALL medications you're currently taking:

Medication name	Dosage	Frequency

6. Any surgery done or expected? When? Type? ____________________
7. Any history of abnormal pap test? ____________________
8. What class? (I, II, III, IV) When? ____________________
9. How often to Doctor for follow-ups? ____________________
10. Any suspicion of malignancy? ____________________
11. Any history of infertility? ____________________
12. Date of last mammogram: ____________________

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

Employee signature: ____________________ Date: __________