

Hernia 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. Location of hernia: abdomen esophagus Other _____

2. Type: hiatal inguinal epigastric Other _____

3. Any surgery performed or expected? _____

When? _____

4. Any prior occurrence of hernia? _____ When? _____

5. Current medications:

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

6. Any recommendations for further treatment or procedures? Yes or No

Please explain: _____

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

Employee signature: _____ Date: _____

