AGC HEALTH PLAN
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Hypertension 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. Date hypertension first diagnosed? ______________________________
2. Type of treatment:______________________________

Current medications	Dosage	Frequency

Has there been a change to your current medications/dosages in the past six months?

If so, how has it changed? ______________________________

3. Date physician was last seen: __________________ Recommendation(s) ____________

____

Frequency of visits: ______________________________

Please give 3 blood pressure readings from 3 separate dates, within the past 6 months.

Readings can be from Dr.'s office, home, pharmacy, etc. B/P readings MUST be provided.

1st date __________________ Reading __________________

2nd date __________________ Reading __________________

3rd date __________________ Reading __________________

Average over the past year ______________________________

4. Are you currently pregnant? Yes or No Date due: __________________
5. Are you currently smoking or using any forms of tobacco? __________________
6. Any history of stroke, diabetes or heart-related condition?__________________

If so, complete the appropriate questionnaire(s).

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

Employee signature: ______________________________ Date: ____________