

Muscular Dystrophy Multiple Sclerosis 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. Is the diagnosis Muscular Dystrophy or Multiple Sclerosis? _____

2. What problems or symptoms have been experienced with this condition? E.g. vision disturbances, tremors, muscle weakness or paralysis, etc. List specific muscles affected: _____

3. What tests have been done? Give name of test, date and result: _____

4. What type of treatment was done, either past or present. Include any physical therapy, surgery, hospital stays, etc _____

5. List all medications taken

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

6. How often does the person visit the Doctor's office or medical clinic for this condition _____ When was the last visit and what was the recommendation? _____

7. Please list any disability or limitations from disease: _____

Can person with condition provide his or her own daily care? Yes or No

8. Have future tests, surgery or treatment been scheduled, prescribed or recommended? _____ If yes, please explain: _____

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

Employee signature: _____ Date: _____

