

# Pre-Cancer Cells At Pap Test 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: \_\_\_\_\_

- Class (circle one)
- I. Normal or variation of normal
  - II. ASCUS
  - III. Pre-cancerous changes
  - IV. Invasive cancer

Any history of abnormal pap test? Yes or No

Symptoms experienced: \_\_\_\_\_

Treatment: \_\_\_\_\_

Date(s) of treatment: \_\_\_\_\_

Ongoing? Yes or No

Any surgery done or expected? \_\_\_\_\_ When? \_\_\_\_\_

Type? \_\_\_\_\_

Hospitalization: \_\_\_\_\_ Outpatient length of stay: \_\_\_\_\_

Inpatient length of stay: \_\_\_\_\_

Follow-ups; How often? \_\_\_\_\_

Findings: \_\_\_\_\_

Recommendations for further treatment or procedures \_\_\_\_\_

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

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

