

Thyroid 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. Name of specific diagnosis? _____

2. Overactive (_____) Underactive (_____)

3. Symptoms experienced: _____

4. Goiter present? _____

5. Any suspicion or history of malignancy? _____

6. Current medications:

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

7. Types and date of treatment received, i.e. hospitalizations, surgery, etc: _____

8. Ever hospitalized for this? _____

9. Why? When? _____

10. Any surgery expected or recommended? _____

When? Why? _____

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

Employee signature: _____ Date: _____

