

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Form No. \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Exact diagnosis of condition: \_\_\_\_\_

2. Have you had or ever been treated for any of the following? Check all that apply.

**Gastroesophageal reflux (GERD)** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Difficulty swallowing (dysphasia)** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Hiatal hernia** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Esophageal stricture** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Esophagitis** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Esophageal spasm** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Name of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Heartburn** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Reflux esophagitis** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Name of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Gastritis** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Name of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Gastroenteritis** Date of first episode: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_

Date of last episode: \_\_\_\_\_ Type of diet: \_\_\_\_\_ Name of medications, include amount taken per day and how often per day: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

**Ulcer** Date, duration, location and treatment of first episode: \_\_\_\_\_

Date, duration, location and treatment of last episode: \_\_\_\_\_

Have you ever had testing done for this condition such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc?

Yes  No If yes, when and what were the results: \_\_\_\_\_

Number of episodes in the last 4 years: \_\_\_\_\_ Is ulcer present at this time?  Yes  No Have you ever had any complications such as anemia, vomiting blood, blood in stool, perforation, or other symptoms relating to your ulcer?  Yes  No

If yes, provide date(s) of episodes and details: \_\_\_\_\_

Are you on medication for your ulcer?  Yes  No If yes, please list name of medications, amount taken per day and how often: \_\_\_\_\_

3. Have you been hospitalized or had surgery for any of these conditions or other related conditions?  Yes  No

If yes, give details of hospitalization such as date of admission, length of stay, treatments received, testing, type of surgery if done and name and address of hospital: \_\_\_\_\_

4. Please list your exact current height: \_\_\_\_\_ weight: \_\_\_\_\_

5. Do you use tobacco?  Yes  No

6. Name and address of treating physician: \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date