



DIGESTIVE QUESTIONNAIRE
(Complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Exact diagnosis of condition: _____

2. Have you ever been diagnosed or treated for:

- | | |
|---|---|
| <input type="checkbox"/> Gastroesophageal Reflux (GERD) | <input type="checkbox"/> Esophageal Spasm |
| <input type="checkbox"/> Esophageal Stricture | <input type="checkbox"/> Reflux Esophagitis |
| <input type="checkbox"/> Esophagitis | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Difficult swallowing (Dysphagia) | <input type="checkbox"/> Heartburn |

3. Date of first episode? _____ # episodes in last year? _____ Date last episode? _____

4. Are you on a special diet or do you use regular medicine for the condition? Yes No

Name of Medication:	Dosage:	Frequency (ie., daily, as needed)
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Have you had any special tests or X-rays? Yes No.

When? _____

Type of test? _____

Results and diagnosis? _____

6. Have you been hospitalized or had surgery for this or any other related condition? Yes No

If yes, name of hospital : _____

Surgery date(s): _____ Hospitalization date(s): _____

Details of surgery or hospitalization: _____

7. What is your current height? _____ and weight? _____

8. 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 that the insurer will rely on these statements when determining eligibility.

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

Date

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