



# ENDOMETRIOSIS QUESTIONNAIRE (Complete all questions)

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

Name of person treated/relationship to applicant: \_\_\_\_\_

1. Date of first episode: \_\_\_\_\_

2. # of episodes in last year: \_\_\_\_\_

3. Date of last episode: \_\_\_\_\_

4. Have you had any special test or x-rays? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, type of test? \_\_\_\_\_

Results and diagnosis: \_\_\_\_\_

5. Have you had any surgery?

If yes, give details: \_\_\_\_\_

6. Do you use regular medication for this condition? Yes \_\_\_\_\_ No \_\_\_\_\_

**Name of Medication:**

**Dosage:**

**Frequency**

\_\_\_\_\_  
\_\_\_\_\_

7. 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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