



**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)
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_____
_____
_____

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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