

**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:

- Gastroesophageal Reflux (GERD)
- Esophageal Stricture
- Esophagitis
- Difficult swallowing (Dysphagia)

- Esophageal Spasm
- Reflux Esophagitis
- Hiatal Hernia
- 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