

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