

CROHN'S AND ULCERATIVE COLITIS QUESTIONNAIRE

Please fax back to IPA at 781 643-2775

Name: _____ DOB: _____

1. At what age did the client first start noticing symptoms of crohn's or ulcerative colitis? _____
2. When was the diagnosis actually made? _____

3. What is the name of the physician? _____

4. How severe is the disease? _____
5. What type of medications are you taking? _____

6. What studies have you had to make the diagnosis of crohn's or ulcerative colitis? _____

7. Have you ever had to have any surgeries, if so, when and where? _____

8. When was the last attack and how frequent are the attacks? _____

9. Have your liver function studies remained normal? _____
10. Have you had any weight loss? _____
11. How much of the colon is involved? _____
12. Have you ever lost any time from work due to crohn's or ulcerative colitis? _____

Agent Name: _____

Phone Number: _____ Fax No: _____

Date: _____ E-mail Address: _____

Please circle the associate you work with. Russ, Rhonda, Leo

