

ULCERATIVE COLITIS/CROHN'S DISEASE

Client's Name _____

1. Date of first symptoms: _____

2. Dates of diagnosis: _____

How was it diagnosed:

By History? yes no

By X-Ray Studies? yes no

By Biopsy of Bowel? yes no

3. Current symptoms: _____

4. Current medications?

If on Steroids,

Type? _____

Dosage? _____

How long you been on them? _____

5. Any surgery? yes no

When? _____

Agents name:

Agents Tell #

Agent Fax #

Date Submitted:

Agents e-mail address:

PLEASE FAX TO BEST MARKETING AT 1-781 643-2775