



South Carolina

BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association

BlueCross Blue Shield of South Carolina
Cholesterol Questionnaire

1. Name of Applicant: _____

Applicant's Social Security Number or BlueCross ID Number: _____

2. A. Date elevated cholesterol first diagnosed? _____

B. What was the cholesterol reading at diagnosis? _____

3. List medication(s) and dosage(s) taken: _____

4. A. Please provide most recent blood lipid levels:

Total cholesterol Date _____ Result _____

HDL cholesterol Date _____ Result _____

Triglycerides Date _____ Result _____

B. Height _____ Weight _____ Date Taken _____

5. Has there ever been a diagnosis of, or a suspicion of, coronary artery disease? Please call the doctor's office to confirm. YES NO If yes, please give details. _____

6. Do you have a family history of heart disease? YES NO If yes, provide relationship of family member with this history. _____

7. Has your doctor ever checked your liver functions due to the medication you take? YES NO If yes, please give date(s) and results: _____

The undersigned hereby represents that the information on this questionnaire is complete, true and correctly recorded, and hereby understands that this questionnaire will become a part of the records kept by BlueCross BlueShield of South Carolina.

Applicant's Signature

Date Signed