GYNECOLOGICAL QUESTIONNAIRE – APPLICANT

(This questionnaire will form part of the application)

First Name:		**Last Name:**	
Date of Birth (mm/dd/yyyy):		**Policy/Application No.:**	

1. Please state the precise diagnosis, or nature of the condition. Attach a copy of any medical report.

☐ Ovarian Cyst	☐ Cancer of the Uterus	☐ Others: _____
☐ Cervical Dysplasia	☐ Cervical Cancer	
☐ Endometriosis	☐ Uterine Prolapse	
☐ Ovarian Cancer	☐ Polycystic Ovarian Syndrome	
☐ Uterine Myoma	☐ Pelvic Inflammatory Disease	

2. When was the condition diagnosed or when did you first experience symptoms?

3. Please describe your symptoms:

4. Do you still experience symptoms? ☐ Yes ☐ No

If no, when did you last experience symptoms or last time you had an attack?

5. Were you prescribed medication for this condition? ☐ Yes (Please provide details.) ☐ No

Name of Medication	Date Prescribed (Month/Year)	Dosage	Date Medication Stopped (Month/Year)	Reason

6. Have you had any investigation/test done regarding this condition?

☐ Yes (Please provide details.) ☐ No

Name of Test or Investigation	Date (Month/Year)	Results
☐ PAP Smear		
☐ Ultrasound		
☐ CT Scan		
☐ MRI		
☐ X-ray		
☐ Biopsy		
☐ Others: _____		

7. Is your condition associated with vaginal bleeding, involvement of other organs, or requires more than one surgical intervention?

☐ Yes (Please provide details.) ☐ No

8. Have you been admitted to a hospital/facility due to this condition?

☐ Yes (Please provide details.) ☐ No

Date Admitted	Date Discharged	Name of Hospital/Facility	Reason for Confinement

9. Did you undergo surgery or any non-invasive procedure to resolve this condition?

☐ Yes (Please provide details.) ☐ No

Type of Surgery/Procedure	Date (Month/Year)	Diagnosis

10. If you have not undergone surgery yet, have you been advised by your attending physician to undergo operation or any non-invasive procedure?

☐ Yes (Please provide details.) ☐ No

Type of Surgery/Procedure	Date (Month/Year)	Diagnosis

11. Please provide any additional information that you feel is important.

12. Please provide details regarding the doctors and/or specialists you see in relation to this condition:

Name of Doctor, Hospital or Clinic	Address	Date of Last Consultation (Month/Year)

DECLARATION

I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.

Name:	
Signature:	
Date of Signing:	