THYROID DISORDER 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 if available.		
☐ Hyperthyroidism	☐ Thyroid Nodules, please specify:	☐ Cold ☐ Warm ☐ Hot
☐ Goiter	☐ Thyroid Cyst	
☐ Hypothyroidism	☐ Grave's Disease	
☐ Thyroid Cancer	☐ Others: _____	
☐ Thyroiditis		
1.1 If thyroid cancer, please state the type of cancer:		
☐ Papillary and Mixed cell	☐ Follicular	☐ Medullary
☐ Hurthle cell	☐ Anaplastic or undifferentiated	
1.2 Please state the stage of thyroid cancer.		
2. When was this thyroid condition diagnosed?		
3. Have you had any investigation/test done regarding this condition?		
☐ Yes (Please provide details or attach copy of results.) ☐ No		

Name of Test or Investigation	Date (Month/Year)	Results
☐ Blood Exam: T3, T4, TSH		
☐ Thyroid Antibody Tests		
☐ Thyroglobulin		
☐ Radioactive Iodine Uptake		
☐ CT Scan		
☐ MRI Scan		
☐ PET Scan		
☐ Thyroid Scan		
☐ Thyroid Ultrasound		
☐ Biopsy/Histopathological Result		
☐ Others: _____		

4. 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

5. Did you undergo operation or any non-invasive procedure to resolve this condition?		
☐ Yes (Please provide details.) ☐ No		
Type of Surgery/Procedure	Date (Month/Year)	Diagnosis
☐ Total Thyroidectomy		
☐ Partial Thyroidectomy		
☐ External Irradiation		
☐ Others: _____		

5.1 Did you undergo chemotherapy, RAI/RAIU or external irradiation?			
☐ Yes (Please provide details.) ☐ No			
Procedure	Start Date (Month/Year)	Date of Last Cycle (Month/Year)	Total Number of Cycles

6. Do you have ongoing symptoms?	☐ Yes ☐ No		
7. Were you required to come back for monitoring of your thyroid condition?			
☐ Yes (Please provide details.) ☐ No			
Frequency		Test/s done	
Date of last check-up		Result/s	
8. Was there any history of recurrence?	☐ Yes ☐ No		
9. Please provide any additional information that you feel is important.			
10. 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:	