

**GYNECOLOGICAL QUESTIONNAIRE**

Please fill in ENTIRE FORM using BLOCK CAPITALS

(With reference to Q6q)

Medical/Health Condition concerned: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

ID/Passport No.: \_\_\_\_\_

**ABNORMAL CERVICAL SMEAR TEST**

1. When was the first abnormal smear? \_\_\_\_\_
2. Please provide the results of the smear and the precise diagnosis, if known: \_\_\_\_\_
3. What treatment was given? \_\_\_\_\_
4. Please provide details of any follow-up smear tests, including dates and results: \_\_\_\_\_
5. Regarding the monitoring of your condition: \_\_\_\_\_
- a) State your last follow-up date: \_\_\_\_\_ Next follow-up date: \_\_\_\_\_
- b) If you have been discharged from follow-up, please state when: \_\_\_\_\_

**OTHER GYNECOLOGICAL PROBLEMS**

6. Please state the precise diagnosis if known: \_\_\_\_\_
7. Regarding your symptoms: \_\_\_\_\_
- a) Please describe your symptoms: \_\_\_\_\_
- b) When did the symptoms first occur? \_\_\_\_\_
- c) How frequently did the symptoms occur in the last 12-months? \_\_\_\_\_
- d) When was the last occurrence of the symptoms? \_\_\_\_\_
8. Have you had any operation &/or treatment for this condition or is any operation &/or treatment being considered?  Yes  No.
- a) If "YES", please provide date(s) and full details including type of treatment, names of hospital and consultant/surgeon. \_\_\_\_\_
- b) Have you experienced any symptoms following treatment or surgery?  Yes  No. (If "Yes", please provide details) \_\_\_\_\_
9. Please provide details of your treatment, including names of medication, dosage and frequency of dosage:
- a) Currently: \_\_\_\_\_
- b) In the Past: \_\_\_\_\_
- c) Chinese medicine practitioner or others: \_\_\_\_\_
10. Regarding the monitoring of your condition:
- a) Name and address of your current treating Doctor or Hospital: \_\_\_\_\_
- b) How often is your follow-up? \_\_\_\_\_
- c) State your last follow-up date: \_\_\_\_\_
- d) Next follow-up date: \_\_\_\_\_
- e) If you have been discharged from follow-up, please state when: \_\_\_\_\_

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true.

\_\_\_\_\_  
Signature of the Insured Individual / Main Applicant  
(Signature by Policy Owner if the Insured Individual is a Minor)

\_\_\_\_\_  
Date