UniversalHealth 100

gynecological questionnaire

Please fill in **ENTIRE FORM** using **BLOCK CAPITALS**

Medical/health condition concerned:

Name of Insured Person:

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 and/or treatment for this condition or is any operation and/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) How often do you need to obtain/purchase regular medication? _____
   d) Chinese medicine practitioner or others: _____
10. Regarding the monitoring of your condition:
    Name & address of your current treating Physician and/or Hospital:

    a) How often do you attend follow-up? _____
    b) State your last follow-up date: _____ Next follow-up date: _____
    c) 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 Person
(Signature by Policyholder if the Insured Person is a Minor)

Date

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