GYNAECOLOGICAL QUESTIONNAIRE

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PROHealth

Important Notice

Statement pursuant to Section 25(5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof): You are to disclose in this Application Form, fully and faithfully, all the facts which you know or ought to know in respect of the risk that is being proposed. Otherwise, the Policy issued hereunder may be void. Neither this Application Form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specific terms, conditions and exclusions applicable to this insurance are set out in the Policy, a copy of which is available upon request.

Please fill in ENTIRE FORM using BLOCK CAPITALS

Medical/health condition concerned: ______________________

Name of Insured Person: ______________________

ID/Passport Number: ______________________

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?

____

Please provide details of any follow-up smear tests, including dates and results:

____

4. 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

5. Please state the precise diagnosis if known: ______________________

6. Regarding your symptoms:

a) Please describe your symptoms: ______________________

7. 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 complete and true.

______________________ ______________________

Signature of the Insured Person
(Signature by Policyholder if the Insured Person is a Minor)

Date

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