Gynaecological disorders questionnaire - Applicant

(Includes abnormal cervical/PAP smear, hysterectomy, menstrual problems, etc.)

Full name:

Application number:

Abnormal cervical smear test:

1. When was your first abnormal cervical smear?

2. What did the doctor tell you was the result of the cervical smear? If you have a written confirmation of the result, please attach a copy when returning this form.

3. What treatment was given? If surgery of any kind, please advise type, dates and advise details of the result.

4. Please provide details of any subsequent cervical smears, including dates and results.

5. Are you still being followed-up? Yes ☐ No ☐

If YES, please state how often and when last seen.

If NO, when were you discharged from follow-up?

Hysterectomy:

6. What was the reason for the hysterectomy?

7. When was it performed?

8. What were you told were the results of the hysterectomy?

9. Did you receive any other treatment apart from the hysterectomy? Yes ☐ No ☐

If YES, please provide details including name(s) of medication.

10. Are you still being followed-up? Yes ☐ No ☐

If YES, please state how often and when last seen.

If NO, when were you discharged from follow-up?

Other gynaecological problems:

11. Please state the diagnosis as advised to you by your doctor.

12. Regarding your symptoms:

a) Please describe your symptoms.

b) When did the symptoms first occur?

c) How frequently do symptoms occur, e.g. how often in the last 12 months?

d) When did you last experience these symptoms?

13. Have you been investigated by a medical profession (e.g. gynaecologist or family doctor) for this condition or are you awaiting any such investigation? Yes ☐ No ☐

If YES, please provide full details including type of investigation, dates and results and name and address of the doctor who did these investigations.

14. Have you had surgery for this condition or is surgery being considered? Yes ☐ No ☐

If YES, please provide date(s) and full details including type of surgery, date and name of hospital and consultant/surgeon.

15. Please provide details of any continuing treatment or medication. Include names of medication, dosage and how often taken.

16. Are you still being followed-up? Yes ☐ No ☐

If YES, please state how often and when last seen.

If NO, when were you discharged from follow-up?

17. Please provide any additional information on your condition which you feel will be helpful in processing your application.

I declare that the answers I have given are, to the best of my knowledge, true 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 the contract.

Signature

Date