



GYNECOLOGICAL QUESTIONNAIRE

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

(With reference to Q6P)

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 enrolment form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specified terms, conditions and exclusions applicable to this insurance are set out in the policy, a copy of which is available upon request.

Medical/Health Condition concerned: _____

Name of Insured: _____

ID/Passport No.: _____

ABNORMAL CERVICAL SMEAR TEST

- When was the first abnormal smear? _____
- Please provide the results of the smear and the precise diagnosis, if known: _____
- What treatment was given? _____
- Please provide details of any follow-up smear tests, including dates and results: _____
- Regarding the monitoring of your condition:
 - State your last follow-up date: _____ Next follow-up date: _____
 - If you have been discharged from follow-up, please state when: _____

OTHER GYNECOLOGICAL PROBLEMS

- Please state the precise diagnosis if known: _____
- Regarding your symptoms:
 - Please describe your symptoms: _____
 - When did the symptoms first occur? _____
 - How frequently did the symptoms occur in the last 12-months? _____
 - When was the last occurrence of the symptoms? _____
- Have you had any operation &/or treatment for this condition or is any operation &/or treatment being considered? Yes No.
 - If "Yes", please provide date(s) and full details including type of treatment, names of hospital and consultant/surgeon. _____
 - Have you experienced any symptoms following treatment or surgery? Yes No. If "Yes", please provide details: _____
- Please provide details of your treatment, including names of medication, dosage and frequency of dosage:
 - Currently: _____
 - In the Past: _____
 - Chinese medicine practitioner or others: _____
- Regarding the monitoring of your condition:
 - Name and address of your current treating Doctor or Hospital: _____
 - How often is your follow-up? _____
 - State your last follow-up date: _____
 - Next follow-up date: _____
 - 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 / Main Applicant
(Signature by Policyholder if the insured person is a Minor)

Date