# GYNAECOLOGICAL DISORDER QUESTIONNAIRE

Reset Form

| **Name** | Date of Birth (dd/mmm/yy) | Application # |
|---|---|---|
| | | |

**1.** When did the first symptom occur or when was the condition first detected?

Has any specific cause been identified for your condition?

How often do symptoms occur and how long to they last?

When did you last have symptoms?

Date & results of last PAP test: ❍ never had one

Date & results of last pelvic or abdominal ultrasound:

Have you ever had evidence of cancer or of a pre-cancerous condition? ❍ Yes ❍ No

Do you have any tests pending? If so, please state test & scheduled date:

**2.** Are you currently experiencing any symptoms? ❍ Yes ❍ No If no, how long have you been symptom free? _____
If yes, describe current symptoms:

Name address & phone number of medical advisor(s) consulted:

| Name | Address (number and street) | City | Province | Telephone |
|---|---|---|---|---|
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Date of last medical advisor's consult (dd/mmm/yy):

Details of any medication taken (type, dose, frequency):

❍ Still taking medication | Date medication was stopped (dd/mmm/yy):

**3.** Have you required any surgery or other treatment for your condition? ❍ Yes ❍ No If yes, please give details below.

Were any follow-up visits recommended? ❍ Yes ❍ No If yes, please give details below.

Have you ever been hospitalized for this condition? ❍ Yes ❍ No If yes, please give details below.

Have you ever required emergency treatment for this condition? ❍ Yes ❍ No If yes, please give details below.

Is there any physical restriction or impairment because of your condition? ❍ Yes ❍ No If yes, please give details below.

Have your job duties or leisure activities been affected in any way or have you lost any time from work because of your condition? ❍ Yes ❍ No
If yes, please give details below.

I hereby declare that the above answers are complete and true, and agree that they shall form part of my application for the policy requested.

| Signature of Applicant | Signature of Witness | Date (dd/mmm/yy) |
|---|---|---|
| X | X | |





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