UniversalHealth 100
MEDICAL INSURANCE PLAN
全健100醫療保險計劃

ZURICH®

GYNECOLOGICAL QUESTIONNAIRE

Please fill in **ENTIRE FORM** using **BLOCK CAPITALS** (With reference to Q6P)

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 &/or treatment for this condition or is any operation &/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) Chinese medicine practitioner or others: ____________________
10. Regarding the monitoring of your condition:
    a) Name and address of your current treating Physician or Hospital: ____________________
    b) How often is your follow-up? ____________________
    c) State your last follow-up date: ____________________
    d) Next follow-up date: ____________________
    e) 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