



GYNAECOLOGICAL DISORDERS QUESTIONNAIRE

Name:

Proposal No.:

Please complete the section most appropriate to you providing full details. Once you have completed all the questions and read the declaration please sign and date where applicable.

A. Abnormal Smear

1. When was your first abnormal cervical smear?

2. What was the result of the cervical smear? If you have 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, date and details of the result.

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

5. Please confirm the name and address of all doctors and specialists attended.

6. Are you still being followed up? Yes ☐ No ☐

If 'Yes', please state how often and when last seen. If 'No', please advise date of discharge.

B. Hysterectomy

1. What was the reason for the hysterectomy and when was the condition first diagnosed?

2. When was it performed?

3. Did you receive any other treatment apart from the hysterectomy? Yes ☐ No ☐
If 'Yes', please provide full details including the names of any medication prescribed.

4. Are you still being followed up? Yes ☐ No ☐
If 'Yes', please state how often and when last seen. If 'No', please advise the date of discharge.

5. Please provide names and address of any specialist attended in relation to the above.

C. Other Gynaecological problems

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

2. 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?

3. Have you been investigated by a medical professional (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 the name and address of the doctor who carried out these investigations.

4. Have you had any surgery for this condition or is surgery being considered? Yes ☐ No ☐
If 'Yes', please provide full details including type of surgery, date and name of consultant.

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

6. Are you still being followed up? Yes ☐ No ☐

If 'Yes', please state how often and when last seen. If 'No', please advise date of discharge.

7. Please provide any other information about this condition that you think would be helpful to us in processing your application

I declare that:

- The answers above are true and complete to the best of my knowledge
- I have not withheld any information that may influence the assessment or acceptance of this application.

I agree that:

- This questionnaire will form part of the application to Royal London
- If the answers to any of the questions changes before Royal London assumes risk on the plan, I'll tell Royal London in writing
- If I do not give Royal London all facts that are likely to influence the assessment and acceptance of this application, any plan issued as the result of this application may be cancelled or the terms changed and any claims may be refused.

Signed:

Date:

/ /