

MATERNITY QUESTIONNAIRE

To be completed by the applicant
(PLEASE USE BLOCK LETTERS)



1. POLICYHOLDER'S INFORMATION

Name	Last	First	M.I.
Policy number			

2. APPLICANT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM/DD/YY	Height <input type="checkbox"/> M <input type="checkbox"/> Ft	Weight <input type="checkbox"/> Kg <input type="checkbox"/> Lb
Gynecologist's name			Telephone

3. GYNECOLOGICAL AND OBSTETRIC HISTORY

Number of pregnancies		Number of natural deliveries	
Number of premature births		Number of C-sections	
Number of miscarriages		Number of therapeutic interruptions of pregnancy	

In case of C-section, miscarriage, or therapeutic interruption of pregnancy, please provide the following information.

Date	Name of treating physician	Telephone
MM/DD/YY		
Name of hospital		
Reason		
Date	Name of treating physician	Telephone
MM/DD/YY		
Name of hospital		
Reason		

Please answer the following questions and explain any affirmative answer:

1	Have you or a family member had a child with a birth defect, congenital or hereditary illness, multiple pregnancy, or any complication of the pregnancy or delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Have you ever had an ectopic pregnancy, pre-eclampsia, eclampsia, placenta previa, or blood incompatibility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Have you ever been diagnosed or treated for any gynecological disorder, infertility, abnormal Pap smear, endometriosis, fibroids, or any menstrual disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have you had any surgery on the uterus or reproductive organs (ovaries, tubes, uterus, vagina, vulva, breasts), D&C, conization of the cervix, or any other pelvic surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Have you ever been diagnosed or treated for cardiovascular disorders, hypertension, diabetes, anemia, renal or hormonal disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Have you ever been diagnosed or treated for any other gynecological or obstetric disorder not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Do you smoke cigarettes or consume any nicotine products? If "Yes", indicate:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Type	

#	Condition, surgery, or treatment	From date	To date
		MM / DD / YY	MM / DD / YY
		MM / DD / YY	MM / DD / YY
		MM / DD / YY	MM / DD / YY
		MM / DD / YY	MM / DD / YY
		MM / DD / YY	MM / DD / YY
		MM / DD / YY	MM / DD / YY
		MM / DD / YY	MM / DD / YY

4. APPLICANT'S SIGNATURE

Date	MM / DD / YY	Signature	
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