MATERNITY QUESTIONNAIRE

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

Bupa

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 / YYYY	Height ☐ M ☐ Ft		Weight ☐ Kg ☐ 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 / YYYY		
Name of hospital		
Reason		
Date	Name of treating physician	Telephone
MM / DD / YYYY		
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?	☐ Yes	☐ No
2	Have you ever had an ectopic pregnancy, pre-eclampsia, eclampsia, placenta previa, or blood incompatibility?	☐ Yes	☐ No
3	Have you ever been diagnosed or treated for any gynecological disorder, infertility, abnormal Pap smear, endometriosis, fibroids, or any menstrual disorder?	☐ Yes	☐ No
4	Have you had any surgery or the uterus or reproductive organs (ovaries, tubes, uterus, vagina, vulva, breasts), D&C, conization of the cervix, or any other pelvic surgery?	☐ Yes	☐ No
5	Have you ever been diagnosed or treated for cardiovascular disorders, hypertension, diabetes, anemia, renal or hormonal disorders?	☐ Yes	☐ No
6	Have you ever been diagnosed or treated for any other gynecological or obstetric disorder not mentioned above?	☐ Yes	☐ No
7	Do you smoke cigarettes or consume any nicotine products? If "Yes", indicate:	☐ Yes	☐ No
	Type	Amount per day	

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

4. APPLICANT'S SIGNATURE			
Date	MM / DD / YYYY	Signature	

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