

# 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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