Manulife

Attending Obstetrics Statement

A. Details of Applicant

Policy No:	Name of Applicant (as in NRIC / Passport):	NRIC / Passport No:

B. Attending Obstetrics' Statement

Part I: General Information

1.	a) How long have you known the Applicant?	
	b) Please state the date of last follow-up.	

Height	cm
Weight before pregnancy (if known)	kg
Current weight	kg

Blood Pressure Date: _____ (DD/MM/YYYY)	1st	2nd	3rd
Systolic			
Diastolic (5th phase)			

First Day of the Last Menstrual Period (LMP)	(DD/MM/YYYY)
Expected Date of Delivery (EDD)	(DD/MM/YYYY)
Gestational Age at Last Appointment Date Date: _____ (DD/MM/YYYY)	Week Day
Current Gestational Age Date: _____ (DD/MM/YYYY)	Week Day
Gestational Age by Ultrasound (if performed) Date: _____ (DD/MM/YYYY)	Week Day
Date: _____ (DD/MM/YYYY)	Week Day

Gravida	
Para	

Urinalysis	Date: _____ (DD/MM/YYYY)		
Specific Gravity		Sugar	
Albumin		Others (Please state if any):	
Blood			

Part II: Previous Pregnancy

2. Please give details regarding the Applicant's previous (if any, including miscarriage and abortion)

Date (MM/YYYY)	Current Child's Age or Gestational Age (if miscarriage/abortion)	Gender	Birth Weight (kg)	Cause and Complication if any (Mother / Child)	Child's/Mother's Current Health Condition (Full or incomplete recovery with details)

Part III: Family History

3. Has the Applicant, or the biological father of the foetus or any immediate family members of the Applicant or biological father ever been diagnosed with any of the following?
   - Thalassaemia, Duchenne Muscular Dystrophy, Hemophilia, Huntington's Disease or any congenital and genetic disorders

Applicant		
Relationship	Disease/Disorder	Onset Age

Foetus' Biological Father		
Relationship	Disease/Disorder	Onset Age

Part IV: Past or Present Obstetrics History

Please answer the following:

4. Is the Applicant's current pregnancy conceived through in-vitro fertilization (IVF), Intrauterine Insemination (IUI), Intracervical Insemination (ICI) or other forms of artificial, enhanced or assisted insemination? ☐ Yes ☐ No

5. Is the Applicant currently carrying more than one foetus (e.g. Twins, triplets, quadruplets, etc)? ☐ Yes ☐ No

6. Has the Applicant ever had or received counselling, medical advice or treatment for any of the following during her past or present pregnancy?

a)	Excessive or poor weight gained during pregnancy period?	☐ Yes	☐ No
b)	Per vagina (PV) spotting or haemorrhage?	☐ Yes	☐ No
c)	Pregnancy induced hypertension / Pre-eclampsia / Eclampsia?	☐ Yes	☐ No
d)	Gestational Diabetes Mellitus?	☐ Yes	☐ No
e)	Glycosuria? Proteinuria?	☐ Yes	☐ No
f)	Any other abnormal urine test?	☐ Yes	☐ No
g)	Anaemia?	☐ Yes	☐ No
h)	Cervical incompetence?	☐ Yes	☐ No
i)	Placenta problems (including abruption placenta, placenta previa)?	☐ Yes	☐ No
j)	Urinary Tract Infection?	☐ Yes	☐ No
k)	Intrauterine infection? Leakage of amniotic fluid?	☐ Yes	☐ No
l)	Premature uterine contraction?	☐ Yes	☐ No
m)	Intrauterine growth retardation? Inter-uterine foetal demise?	☐ Yes	☐ No
n)	Amniotic fluid embolism?	☐ Yes	☐ No
o)	Psychological or psychiatric conditions?	☐ Yes	☐ No
p)	Any other abnormalities which are not mentioned above?	☐ Yes	☐ No

Part V: Foetal Assessment

7. Is there any or do you find any evidence of past or present disease or abnormality of the following?

a)	Foetal growth (bi-pariental diameter, femur length and abdominal circumference)?	☐ Yes	☐ No
b)	Foetal weight?	☐ Yes	☐ No
c)	Mal-position or presentation?	☐ Yes	☐ No
d)	Amniotic fluid volume (polyhydromnios or oligohydromnios)?	☐ Yes	☐ No
e)	Foetal heart?	☐ Yes	☐ No

f)	Foetal movement?	☐ Yes	☐ No
g)	Any other foetal anomalies?	☐ Yes	☐ No
h)	Any blood screening, amniocentesis, triple test done?	☐ Yes	☐ No
i)	Any other abnormalities which are not mentioned above?	☐ Yes	☐ No

If any of the answers for Question 4 to 7 is 'Yes', please indicate the Question number(s) and provide details below.
Please indicate on the next page if more writing space is required.

Question	Condition / Diagnosis	Year of Diagnosis	Tests performed, date & results	Treatment & Medication	Name & Address of Doctor

Please attach all the test/investigation reports (if available).

_____	_____	_____
Name of Registered Specialist in Obstetrics & Gynaecology and Clinic/Hospital Stamp	Signature of Registered Specialist in Obstetrics & Gynaecology	Date (DD MMM YYYY)