

ANSWERS MADE TO THE MEDICAL EXAMINER
 In continuation of and forming part of application for insurance

Print full name of Proposed Insured _____
 Born: Month _____ Day _____ Year _____
 1. Name of your doctor _____ Date last seen _____
 Address _____ Reason _____
 _____ Findings _____
 Doctor's Phone Number _____

2. Has the proposed Insured ever used any form of tobacco or nicotine-based products? Yes No
 If "Yes", when did the proposed Insured last use tobacco or nicotine-based products: Date: _____
 3. Family History: Has any of your immediate family members (parents, brothers, or sisters) died from cancer, diabetes or cardiovascular disease prior to age 60? Yes No
 If "Yes", identify family member, disorder, and age at death _____

	DETAILS of "Yes" answers. List questions, circle item. List diagnoses, dates, and durations. Give names, addresses, and phone number of all doctors, hospitals and medical facilities.	
	Yes	No
4. Have you ever been treated for, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following?		
a. Dizziness, fainting spells, epilepsy, depression, anxiety, mental disorder, or any disease or disorder of the brain or nervous system?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma, bronchitis, tuberculosis, pneumocystis, or any disorder of the lungs or respiratory system?....	<input type="checkbox"/>	<input type="checkbox"/>
c. High blood pressure, chest pain, shortness of breath, heart murmur, rheumatic fever or any disease or disorder of the heart, hemophilia or coagulation disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Any disease or disorder of the kidney, bladder or prostate?.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints or muscles?.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes, or sugar, albumin or blood in the urine?	<input type="checkbox"/>	<input type="checkbox"/>
h. Cancer or a tumor or cyst of any kind or enlargement of lymph nodes?.....	<input type="checkbox"/>	<input type="checkbox"/>
i. Varicose veins, varicose ulcer or phlebitis, syphilis, or a hernia?.....	<input type="checkbox"/>	<input type="checkbox"/>
j. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>
k. Any advice or treatment for alcoholism, drug addiction, drug abuse or other substance abuse?..	<input type="checkbox"/>	<input type="checkbox"/>
l. Any immune deficiency disorder, AIDS or the AIDS Related Complex (ARC)?.....	<input type="checkbox"/>	<input type="checkbox"/>
m. Any other illness or injury requiring blood transfusion or other medical attention?.....	<input type="checkbox"/>	<input type="checkbox"/>
n. Any special examinations or laboratory tests such as X-rays, or electrocardiograms, blood tests other than AIDS-related blood tests, or urine tests during the past 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>

I represent that these statements are true and complete to the best of my knowledge and belief. They are part of my insurance application.

Signed at _____ City _____ State _____ Signature of Proposed Insured _____

Date _____ Witness _____ Signature of Medical Examiner _____

M.D.
 D.O.
 Para Med
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MEDICAL EXAMINER'S REPORT

5. Height (In shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen (at Umbilicus)	Details of "Yes" answers. (Identify item.)
ft. in.	lbs.	in.	in.	in.	

6. Blood pressure sitting position prior to exercise – (If initial BP exceeds 140/90, record two additional readings.)

Systolic _____
Diastolic _____

7. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per minute			

8. Heart. Is there any:

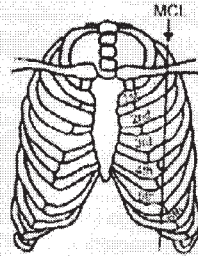
Enlargement Yes No Dyspnea Yes No
Murmur* Yes No Edema Yes No

*Describe below

- Location _____
- Constant
 - Inconstant
 - Transmitted
 - Localized
 - Systolic
 - Presystolic
 - Diastolic
 - Soft (Gr. 1-2)
 - Mod. (Gr. 3-4)
 - Loud (Gr. 5-6)
 - After Exercise:
 - Increased
 - Decreased
 - Unchanged
 - Absent

Indicate:

- Apex by X
- Murmur Area by ⊙
- Point of greatest intensity ○
- Transmission by ↓



WHAT IS YOUR IMPRESSION?

9. Is there on examination any abnormality of the following:

(Circle applicable items and give details)

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Nervous system..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Musculoskeletal system..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Eyes, ears, nose, mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Skin, lymph nodes, thyroid gland..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Lungs or respiratory system..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Abdomen..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Hernia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. External genitalia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Varicose veins or ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Other abnormalities..... | <input type="checkbox"/> | <input type="checkbox"/> |

10. Urinalysis: Specific gravity	Albumin	Sugar	Send specimen to laboratory with each exam: Specimen forwarded on: Month _____ Day _____ Year _____
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11. How long and how well have you known the applicant?

12. Comments (if any):

13. Examination made at examiner's office applicant's home applicant's office other _____
on: Month _____ Day _____ Year _____ at _____ a.m. _____ p.m.

<p>Name of agent: _____</p> <p>Med. Fee: \$ _____</p> <p>Other tests requested by agent:</p> <p>ECG \$ _____</p> <p>X-Ray \$ _____</p> <p>Dried Blood Profile (Mail kit to laboratory) \$ _____</p> <p>Full Blood Profile (Mail kit to laboratory) \$ _____</p> <p>Other _____ \$ _____</p> <p style="text-align: right;">Total Fee \$ _____</p>	<p>By (print name) _____ <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Para Med</p> <p>Signature _____</p> <p>Address _____ Street City State ZIP _____-_____-____ or _____</p> <p>Social Security Number _____ Tax ID Number _____</p>
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