

MEDICAL EXAMINER'S REPORT

Part III

9. a. Measured Height (in shoes) ft. in.	Scale Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.
b. Any change of weight in past year? _____ Cause? _____				
c. Is appearance unhealthy? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Details of "Yes" answers. (Identify item.)

10. **Blood Pressure** (Record All readings)

Stystolic			
Diastolic {	4th phase		
	5th phase		

11. **Pulse:**

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

12. **Heart:** Is there any:

Enlargement Yes No Dyspnea Yes No History of rheumatic fever Yes No

Murmur(s) Yes No Edema Yes No

(describe below — if more than one, describe separately)

Location: (Mitral, aortic, pulmonary, elsewhere)

Character:

	Murmur 1	Murmur 2
Constant	<input type="checkbox"/>	<input type="checkbox"/>
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
Localized	<input type="checkbox"/>	<input type="checkbox"/>

Timing:

Systolic	<input type="checkbox"/>	<input type="checkbox"/>
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>

Grade:

Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>

After exercise:

Increased	<input type="checkbox"/>	<input type="checkbox"/>
Absent	<input type="checkbox"/>	<input type="checkbox"/>
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>
Decreased	<input type="checkbox"/>	<input type="checkbox"/>

Indicate:

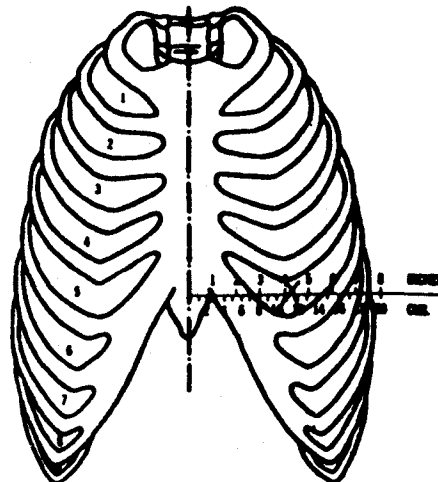
Apex by X

Murmur area by ⊙

Point of greatest intensity by ●

Transmission by ➔

Comments and your diagnoses?



Does the murmur impress you as organic as functional

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

(Circle applicable items and give details)

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? ..	<input type="checkbox"/>	<input type="checkbox"/>
(c) Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Genitourinary system (include prostate)?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

14. Are there any hernias? Yes No Any hemorrhoids? Yes No

15. Are you aware of additional medical history?

(A confidential report may be sent to the Medical Director)

16. Urinalysis:	WBC	RBC	Albumin	Sugar
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Are you forwarding a specimen?

Yes No

PLEASE FORWARD SPECIMEN TO LABORATORY

I Certify that I have carefully examined _____ of _____

in private, at { place of business / home / my office } this _____ day of _____, _____ at _____ A.M. / P.M.

Signature of Examiner _____ Address _____

Name of Examiner _____ Yrs. Patient known _____ \$ _____

(Please Print)

Review report carefully for completeness of all sections. Then mail directly and without exception to the Medical Director at the Home Office of the Company.
THE COMPANY APPRECIATES CONFIDENTIAL INFORMATION ALWAYS

FEE
Soc. Sec. No.
Or Fed. I.D.