



Service Office:
 Life New Business
 197 Clarendon Street
 Boston MA 02116-5010

Medical Exam
John Hancock Life Insurance Company (U.S.A.)
 (hereinafter referred to as The Company)

This form is part of the Application for Life Insurance for the Proposed Life Insured.
 Notice of Disclosure of Information form NB5006 must be used with this Medical Exam if it is being submitted on its own without the main application.
 Print and use black ink. Any changes must be initialed by the Proposed Life Insured.

PROPOSED LIFE INSURED

1. a) Name _____
First Middle Last
- b) Date of Birth _____
month day year
- c) Social Security/Tax ID Number _____
- d) Sex Male Female

SMOKING STATUS

2. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?
 Yes No If 'Yes', provide details below.

Product:	Frequency:	Current	Past	Date Last Used		
				month	day	year
Cigarettes _____	pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars _____	x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

FAMILY QUESTIONS

3. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60? Yes No
4. Please provide the following details.

L I V I N G	Family History	Age	Give Details of Present State of Health
	Father		
	Mother		
	Brothers & Sisters		

D E C E A S E D	Family History	Age	Cause of Death
	Father		
	Mother		
	Brothers & Sisters		

5. a) Name and Address of Personal or Attending Physician

First Middle Last

Street No. & Name Suite No. City State Zip code

b) Telephone No. _____

c) Date last consulted _____ Reason for consultation _____ Diagnosis/Result of visit _____
month day year

d) List any medications (prescription or nonprescription) you are taking currently _____

HEALTH QUESTIONS

Please complete
Details for 'Yes'
answers on
page 3.

6. **Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have:**
- a) Chest pain, angina, congestive heart failure, heart attack, shortness of breath, heart murmur, high blood pressure, irregular heart beat, heart valve disease or any other disease or disorder of the heart or arteries? Yes No
 - b) Aneurysm, transient ischemic attack (TIA), stroke, or peripheral vascular disease? Yes No
 - c) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands? Yes No
 - d) Seizures, fainting, dizziness, epilepsy, convulsions or paralysis? Yes No
 - e) Any nervous, mental or emotional disorder, or received counseling for anxiety, depression, stress, or any other emotional condition? Yes No
 - f) Alzheimer's disease, dementia, memory loss or organic brain syndrome? Yes No
 - g) Multiple sclerosis (MS), muscular dystrophy, ALS (Lou Gehrig's disease), Parkinson's disease or tremors? Yes No
 - h) Injuries due to falls or imbalance? Yes No
 - i) Arthritis, gout, chronic fatigue, fibromyalgia, myalgia, osteoporosis, fractures, or any other bone, joint or muscle disorder? Yes No
 - j) Asthma, sleep apnea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder? Yes No
 - k) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach or intestines? Yes No
 - l) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts? Yes No
 - m) Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells or bone marrow or any lymph node disorders? Yes No
 - n) Disease of the urinary tract, bladder or kidneys, sugar, protein or blood in the urine? Yes No
 - o) Cancer, leukemia, lymphoma, malignant melanoma or tumors of any kind, malignant or benign? Yes No
 - p) Any other health impairment or medically treated condition? Yes No
7. **Within the last 10 years have you had:**
- a) an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness, disease or accident? Yes No
 - b) any diagnostic tests (e.g. blood, urine, EKGs, x-rays etc), whether conducted on an in-patient or out-patient basis? Yes No
8. Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
9. Do you:
- a) have any symptom or medical concern for which you have not consulted a physician or had any consultation, testing or investigation recommended by a physician which has not yet been completed? Yes No
 - b) consume alcoholic beverages? Never Currently In the past
- Complete if **Currently** was selected in 9 b)

Type of beverage	Frequency	Quantity

Complete if **In the past** was selected in 9 b)

Date Stopped _____

Reason Stopped _____
10. **Within the last 10 years have you:**
- a) been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment counseling or participated in a support group? Yes No
 - b) used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens? Yes No
 - c) used any tranquilizers, sedatives or narcotic drugs or any prescription drug except in accordance with physician's instructions? Yes No

Print and use black ink.

PROPOSED LIFE INSURED

1. a) Name _____ b) Date of Birth _____
First Middle Last month day year

SECTION 1

Complete for all paramedicals and medical examinations.

2. a) Height _____
 Did you measure? Yes No
 b) Weight _____
 Did you weigh? Yes No
 c) Any weight change in the past 12 months? Yes No
 If 'Yes', amount _____ Loss Gain
 Reason _____
3. Blood Pressure Readings
 1. 2. 3.
 Systolic _____
 Diastolic _____
4. Pulse Regular Irregular
 Type of irregularity _____
 If extra systoles, No. per min. _____
5. Describe general appearance _____
6. Did anyone accompany the Proposed Life Insured during the examination? Yes No
 If 'Yes', please provide details
 Name of the person who came _____ Relationship to Proposed Life Insured _____
 Why present _____
7. Did the Proposed Life Insured understand and answer all the questions asked in connection with this exam? Yes No
 If 'No', please provide details _____
8. Do you suspect anything unfavorable such as excessive use of alcohol, cigarettes, or drugs? Yes No
 If 'Yes', please provide details _____

SECTION 2

Complete only for medical examinations.

9. On examination is/are there any:
 a) Extra or abnormal heart sounds? Yes No
 b) Murmurs? Yes No
 c) Cardiomegaly or cardiac enlargement? Yes No
 d) Inadequate circulation anywhere? Yes No
 If 'Yes', provide details below. (e.g. shortness of breath, edema, stasis dermatitis, PVD)

Please complete the following heart chart if there are any YES answers to question 9, if there is any pulse irregularity, if any blood pressure reading is over 150/100 or if there is a history of hypertension or heart disease.

Murmur If more than one, describe in Details below.

None Systolic Diastolic | Grade I II III IV V VI | Loud Harsh Rough Soft Blowing

- Signs of Failure**
- Shortness of breath? Yes No
 Cyanosis? Yes No
 Engorgement of neck veins? Yes No
 Swelling of ankles? Yes No
 Rales at lung bases? Yes No

Location
 Area of Murmur by _____ xxxxx
 Transmission by _____



