INSTRUCTION TO THE MEDICAL EXAMINER OR PARAMEDICAL TECHNICIAN

1. Examination is to be made in private and findings are to be treated confidentially. Use Black or Blue-Black ink.
2. Self addressed and stamped envelopes are furnished to approved examiners on request.
3. Help prevent correspondence and delays by seeing that all questions are answered in detail and the examination is mailed promptly.

PART II **Application for Life Insurance to The Lafayette Life Insurance Company** **Use BLACK Ink**

MEDICAL HISTORY QUESTIONNAIRE

1. Print full name of Person being examined _____ Age _____

Amount of insurance applied for: _____

2. When were you last examined for insurance and for what company?

3. a. Name and address of your personal physician? If none, give location of Medical Records.

b. Date and reason last consulted?

c. What treatment was given or medication prescribed?

d. How much time have you lost from work during the last two years because of illness or injuries? ☐ none _____ weeks

4. a. FAMILY HISTORY

	LIVING		DEAD	
	Age	State of Health	Age	Cause of Death
Father				
Mother				
Brothers				
Sisters				

b. Did either parent, brother or sister ever have heart disease, diabetes, stroke or high blood pressure? ☐ Yes ☐ No If "Yes," give details.

ANSWER ALL QUESTIONS IN THIS COLUMN	Yes	No
5. HAVE YOU EVER:		
a. received disability benefits?	☐	☐
b. had high blood pressure or treatment thereof	☐	☐
c. had pain or other discomfort in the chest?	☐	☐
d. had kidney stones, sugar, albumin or blood in the urine?	☐	☐
e. used barbiturates, narcotics, or other drugs, excitants or hallucinogens except as medication prescribed by a physician?	☐	☐
f. been treated for drug habit or alcoholism?	☐	☐
g. smoked cigarettes within the last 12 months?	☐	☐
6. HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS:		
a. heart murmur, palpitation, abnormal pulse or any other heart or circulatory trouble including varicose veins?	☐	☐
b. nervous or mental trouble, convulsions, epilepsy, paralysis, dizzy or fainting spells, or severe headaches?	☐	☐
c. asthma, bronchitis, emphysema, shortness of breath, pleurisy, tuberculosis or any other disorder of lungs?	☐	☐
d. ulcers or any disorder of stomach, liver, gallbladder, pancreas, intestines, appendix, or rectum including hemorrhoids and hernia?	☐	☐
e. disorder of the kidneys, bladder, prostate or genitourinary organs?	☐	☐
f. cancer, tumor, cyst, syphilis, goiter or diabetes?	☐	☐
g. gout, disorder of bone, joint, back, spine, arthritis, rheumatism or any deformity?	☐	☐
h. allergy or any disorder of the spleen or lymph glands?	☐	☐
i. disorder of the skin, eyes, ears, nose, sinuses, throat or larynx?	☐	☐
j. disorder of breasts or pelvic organs?	☐	☐
k. disorder of the immune system?	☐	☐
7. HAVE YOU WITHIN THE PAST 5 YEARS, OTHER THAN AS NOTED ABOVE:		
a. had a checkup, consultation, illness, injury, surgery?	☐	☐
b. been a patient in a hospital, clinic or other medical facility?	☐	☐
c. had an electrocardiogram, x-ray, blood study, or other diagnostic tests?	☐	☐
d. been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐
8. HAVE YOU RECEIVED TREATMENT BY A HEALTH CARE PROVIDER OR TAKEN MEDICATION IN THE PAST 2 YEARS?	☐	☐

	Yes	No
9. DO YOU PARTICIPATE IN REGULAR PHYSICAL EXERCISE? *If "Yes," describe type and frequency.*	☐	☐
10. HAS YOUR WEIGHT CHANGED MORE THAN 10 POUNDS IN THE PAST YEAR? *If "Yes," indicate the gain or loss & why.*	☐	☐
11. In the past ten years have you:		
(1) had or been told you had Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex ("ARC"), or AIDS related conditions?	☐	☐
(2) received advice or treatment in connection with any of the categories mentioned in (1) above?	☐	☐
(3) tested positive for antibodies to the AIDS (Human T-cell Lymphotropic, Type III; HTLV-III) virus or had abnormal T-cell ratio count?	☐	☐

DETAILS OF "Yes" answers. IDENTIFY QUESTION NUMBER (Include diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities.)

I agree that the above questions and answers in this Medical History Questionnaire shall be considered as Part II of the application for life insurance on my life.

I have carefully read all the above questions, statements and answers and all such statements and answers are correctly recorded and are true as set down above to the best of my knowledge and may be relied upon by The Lafayette Life Insurance Company.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Dated at _____ (city) _____ (state) this _____ day of _____, _____

WITNESS: _____ Signature of Medical Examiner & Degree

_____ Signature of Person Being Examined

Part III – MEDICAL FINDINGS TO BE FILLED OUT IN PRIVATE

Make a very careful examination of heart and lungs against bare skin.

MALES ONLY:

1 a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus Relaxed in.

Details of "Yes" answer. (Identify them.)

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Weight change in past year? _____ lbs. ☐ Gain ☐ Loss - Cause?

2. Blood Pressure: (Repeat if over 142/90)

(Record all readings)	1st Reading	2nd	3rd
Systolic			
Diastolic (Phase 5)			

3. Pulse:

	At Rest	**exercise test (25 hops)**	3 Minutes Later
Rate			
Irregularities Per Min.			

4. Heart: Is there any:

(a) Enlargement ☐ Yes ☐ No
(b) Murmur(s) ☐ Yes ☐ No
(c) Dyspnea ☐ Yes ☐ No
(d) Edema ☐ Yes ☐ No

Mitral? _____
Aortic? _____
Pulmonic? _____
Septal? _____

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

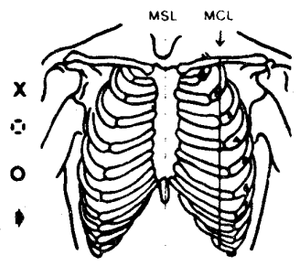
Constant ☐
Inconstant ☐

Transmitted ☐
Localized ☐

Systolic ☐
Presystolic ☐
Diastolic ☐

Soft (Gr. 1-2) ☐
Mod. (Gr. 3-4) ☐
Loud (Gr. 5-6) ☐

Indicate:
Apex by
Murmur area by
Point of greatest intensity by
Transmission by



For comments and your impression? ——►

After exercise:
Absent ☐ Decreased ☐
Increased ☐ Unchanged ☐

What is your interpretation? _____

5. Is there on examination any abnormality of the following:
(Check applicable items and give details.)

		Yes	No
(a)	eyes, ears, nose, mouth, pharynx?	☐	☐
	(If vision or hearing markedly impaired, indicate degree and correction.)		
(b)	skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? . .	☐	☐
(c)	nervous system (include reflexes, gait, paralysis)?	☐	☐
(d)	respiratory system?	☐	☐
(e)	abdomen (included scars)?	☐	☐
(f)	genitourinary system (include prostate)?	☐	☐
(g)	endocrine system (include thyroid and breasts)?	☐	☐
(h)	musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
6.	Are there any hernias or any hemorrhoids?	☐	☐
7.	Are you aware of additional medical history?	☐	☐
8.	Is appearance unhealthy or older than started age?	☐	☐

9. Urinalysis:

SPECIFIC GRAVITY	ALBUMIN	SUGAR

Is specimen being sent to the Lab? ☐ Yes ☐ No

Is blood being sent to the Lab? ☐ Yes ☐ No

Lab One
P.O. BOX 2035
SHAWNEE MISSION, KS 66201

I certify I have carefully examined _____ and that

the examination was made in private at
☐ my office
☐ residence of person being examined
☐ place of business of person being examined

Are you acquainted with person being examined? Yes ☐ No ☐

Date _____

Authorized by (AGENT) _____

_____
(Medical Examiner & Degree) (Please Print)

_____
Street Address

_____
City State

_____
Paramedical Affiliation

FOR H. O. ONLY
☐ Approved _____
☐ Unapproved

This Examination Report must be **mailed directly** to: The Lafayette Life Ins. Co., 1905 Teal Road, P.O. Box 7007, Lafayette, Indiana 47903

REV. 11/99