



**Part III – MEDICAL FINDINGS TO BE FILLED OUT IN PRIVATE**

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

1 a.	<b>MALES ONLY:</b>	Details of "Yes" answer. (Identify them.)																														
Height (In Shoes)  _____ ft. _____ in.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;">Weight (Clothed)</th> <th style="width:15%;">Chest (Full Inspiration)</th> <th style="width:15%;">Chest (Forced Expiration)</th> <th style="width:15%;">Abdomen, at Umbilicus Relaxed</th> </tr> <tr> <td>_____ lbs.</td> <td>_____ in.</td> <td>_____ in.</td> <td>_____ in.</td> </tr> </table>	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus Relaxed	_____ lbs.	_____ in.	_____ in.	_____ in.																							
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_____ lbs.	_____ in.	_____ in.	_____ in.																													
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No      Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Weight change in past year? _____ lbs. <input type="checkbox"/> Gain <input type="checkbox"/> Loss - Cause? _____																																
2. Blood Pressure: (Repeat if over 142/90)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:33%;">1st Reading</th> <th style="width:33%;">2nd</th> <th style="width:33%;">3rd</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	1st Reading	2nd	3rd																												
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(Record all readings) Systolic _____ Diastolic _____ (Phase 5)																																
3. Pulse:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:33%;">At Rest</th> <th style="width:33%;">exercise test (25 hops)</th> <th style="width:33%;">3 Minutes Later</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	At Rest	exercise test (25 hops)	3 Minutes Later																												
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Rate _____ Irregularities Per Min. _____																																
4. Heart: Is there any:	<table style="width:100%;"> <tr> <td style="width:50%;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Mitral? _____</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Aortic? _____</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Pulmonic? _____</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Septal? _____</td> </tr> </table>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aortic? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonic? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Septal? _____																							
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(describe below – if more than one, describe separately) Constant <input type="checkbox"/> Indicate: Inconstant <input type="checkbox"/> Apex by _____	<table style="width:100%;"> <tr> <td style="width:30%;"><input type="checkbox"/> Transmitted</td> <td style="width:30%;">Murmur area by _____</td> <td rowspan="4" style="text-align: center; vertical-align: middle;"> </td> </tr> <tr> <td><input type="checkbox"/> Localized</td> <td>Point of greatest _____</td> </tr> <tr> <td><input type="checkbox"/> Systolic</td> <td>intensity by _____</td> </tr> <tr> <td><input type="checkbox"/> Presystolic</td> <td>Transmission by _____</td> </tr> <tr> <td><input type="checkbox"/> Diastolic</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Soft (Gr. 1-2)</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Mod. (Gr. 3-4)</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Loud (Gr. 5-6)</td> <td></td> <td></td> </tr> </table>	<input type="checkbox"/> Transmitted	Murmur area by _____		<input type="checkbox"/> Localized	Point of greatest _____	<input type="checkbox"/> Systolic	intensity by _____	<input type="checkbox"/> Presystolic	Transmission by _____	<input type="checkbox"/> Diastolic			<input type="checkbox"/> Soft (Gr. 1-2)			<input type="checkbox"/> Mod. (Gr. 3-4)			<input type="checkbox"/> Loud (Gr. 5-6)												
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After exercise: Absent <input type="checkbox"/> Decreased <input type="checkbox"/> Increased <input type="checkbox"/> Unchanged <input type="checkbox"/>	For comments and your impression? _____ →																															
What is your interpretation? _____																																
5. Is there on examination any abnormality of the following: (Check applicable items and give details.)	<table style="width:100%;"> <tr> <th style="width:80%;"></th> <th style="width:10%;">Yes</th> <th style="width:10%;">No</th> </tr> <tr> <td>(a) eyes, ears, nose, mouth, pharynx? .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(If vision or hearing markedly impaired, indicate degree and correction.)</td> <td></td> <td></td> </tr> <tr> <td>(b) skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? ..</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(c) nervous system (include reflexes, gait, paralysis)? .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(d) respiratory system? .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(e) abdomen (included scars)? .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(f) genitourinary system (include prostate)? .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(g) endocrine system (include thyroid and breasts)? .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(h) musculoskeletal system (include spine, joints, amputations, deformities)?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes	No	(a) eyes, ears, nose, mouth, pharynx? .....	<input type="checkbox"/>	<input type="checkbox"/>	(If vision or hearing markedly impaired, indicate degree and correction.)			(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 (included 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"/>	
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6. Are there any hernias or any hemorrhoids? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No																															
7. Are you aware of additional medical history? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No																															
8. Is appearance unhealthy or older than started age? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No																															
9. Urinalysis:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:33%;">SPECIFIC GRAVITY</th> <th style="width:33%;">ALBUMIN</th> <th style="width:33%;">SUGAR</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	SPECIFIC GRAVITY	ALBUMIN	SUGAR																												
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Is specimen being sent to the Lab? <input type="checkbox"/> Yes <input type="checkbox"/> No Is blood being sent to the Lab? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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

FOR H. O. ONLY <input type="checkbox"/> Approved _____ <input type="checkbox"/> Unapproved _____
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