EMSI SM

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# EXAMINATION MANAGEMENT SERVICES, INC.

## PARAMEDICAL SHORT FORM

(NON-MED)

| CASE I.D. # |
|---|
| AGENT |

**INSURANCE COMPANY** _____

| **NAME** (Please Print) LAST | FIRST | MIDDLE | **DATE OF BIRTH** / / |
|---|---|---|---|
| **ADDRESS** CITY | STATE | **PROOF OF IDENTITY** SS# /DL# | **STATE** |

| | YES | NO | GIVE COMPLETE DETAILS TO ALL "YES ANSWERS |
|---|---|---|---|
| 1. Have you during the past 5 years consulted any physician or practitioner for any reason, including routine examination or check up? (If so, date, purpose, illness, injury or condition and give full name and complete address of physician and/or hospital.) | ☐ | ☐ | |
| **2. Do you routinely take medication of any kind?** (If so, state kind, dosage, frequency and reason.) | ☐ | ☐ | |
| **3. A. Do you use tobacco of any kind** (If so, state type of tobacco and frequency.) | ☐ | ☐ | |
| **B. If non-user, have you ever used tobacco?** | ☐ | ☐ | |
| **4. Do you have a personal physician?** (If so, list name and complete address.) | ☐ | ☐ | |

| **5. A. Blood Pressure** | Left Arm | Right Arm |
|---|---|---|
| Systolic | | |
| Diastolic | | |

**B. Pulse** (rate per in.)

**C. Height** (in shoes)

**D. Weight** (clothed)

If answered "NO" state reason in above section

**E. HOS collection** Yes ☐ No ☐

**F. HOS dipstick** Albumin Sugar

**G. Blood collection** Yes ☐ No ☐

**H. Lab used:**

I declare I have read the foregoing and that my answers are correctly recorded to the best of my knowledge and belief. I hereby, authorize the release of medical records or medical knowledge of me to _____ insurance company or information gathering source for the purpose of insurance underwriting.

BRANCH OFFICE STAMP

Signature Date

Witness (Examiner) Date

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