

PART II OF MY APPLICATION TO: _____
Please print names and addresses

Name of Proposed Insured	Birthdate			Sex	Name and Address of Personal Physician:
	Mo.	Day	Yr.		

Name of Writing Agent	Amount Applied for: \$	
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MEDICAL HISTORY (to be recorded by medical examiner): YES NO

So far as you know and believe—

1. Have you ever had any physical disability or impairment? YES NO
2. Is your health impaired at present? YES NO
3. Is any medication being taken?(If "Yes," what?) YES NO
4. Have you had, within the last 10 years, any diagnosis of or treatment of:
 - a. Disease of heart, blood or blood vessels; high blood pressure, or has heart or blood pressure medication ever been advised or taken? YES NO
 - (1) Rheumatic fever or heart murmur? YES NO
 - (2) Coronary artery disease, chest pain or discomfort? YES NO
 - (3) Shortness of breath, abnormal heart rate or rhythm? YES NO
 - b. Disease or disorder of the nose, sinuses, throat? YES NO
 - c. Disease or disorder of lungs or bronchi? YES NO
 - (1) Tuberculosis or exposure to tuberculosis? YES NO
 - (2) Pleurisy, chronic cough or asthma? YES NO
 - (3) Emphysema or chronic bronchitis? YES NO
 - d. Disease or disorder of esophagus, stomach, intestinal tract? YES NO
 - (1) Indigestion, diarrhea, abdominal pain, ulcer, intestinal bleeding or hemorrhoids? YES NO
 - (2) Jaundice, liver or gall bladder diseases? YES NO
 - e. Disease or disorder of kidneys, uterus, bladder? Sugar, albumin, pus, blood or casts in the urine? YES NO
 - (1) Disease or disorder of prostate or testicles? YES NO
 - (2) Disease or disorder of breasts, uterus, tubes, ovaries, abnormal menstruation or pregnancies: present pregnancy? YES NO
 - f. Disease or disorder of brain or nervous system? YES NO
 - (1) Headache, dizziness or unconsciousness? YES NO
 - (2) Convulsion, epilepsy, paralysis? YES NO
 - (3) Neuralgia or neuritis? YES NO
 - (4) Mental illness, depression, anxiety? YES NO
 - g. Diabetes; thyroid or other glandular disorder? YES NO
 - h. Unexplained weight loss, recurrent fever, Epstein-Barr virus or chronic diarrhea? YES NO
 - i. Lymphadenopathy or enlarged lymph nodes? YES NO
 - j. Disorder of the skin, lymph glands, muscles, bones or joints: arthritis; gout; back disorder? YES NO
 - k. Disease or disorder of eye or ear; impaired sight or hearing? YES NO
 - l. Tumor, cancer, or syphilis? YES NO
 - m. AIDS or AIDS Related Complex (ARC)? YES NO
5. Have you ever had:
 - a. Weight gain or loss in past year? (If "Yes," how much?) YES NO
 - b. Treatment by a member of the medical profession for alcohol or drug use? YES NO
 - c. Any condition or treatment not specified above necessitating X-rays, electrocardiograms, operations, hospital confinement or Examinations or treatment by any physician, practitioner, hospital, clinic or institution? YES NO
 - d. Military service rejection or discharge for medical reasons? YES NO
 - e. A history in parents, brothers or sisters of:
 - (1) Diabetes, heart or kidney disease, high blood pressure? YES NO
 - (2) Death before age 60? Relationship, age, cause of death? YES NO
6. Have you used tobacco in any form in the last 12 months? YES NO

Date last seen:	Reason:
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PLEASE GIVE FULL DETAILS FOR ANY "YES" ANSWERS
 List dates, duration, dosage, diagnosis, drug, and doctor (include doctor's address, name and phone number)

7. Family Information	Age If Living	Age At Death	Cause of Death	Number Living	Number Deceased
Father					
Mother					
Brothers & Sisters					

So far as I know and believe, the answers given above are true and complete. I agree that they, with the statements in my application, will be the basis for any insurance issued.

Signature of Medical Examiner _____ Signature of Proposed Insured _____ Date _____

MEDICAL EXAMINATION REPORT - Part I

PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS IN DETAILS SPACE BELOW

EXAMINATION OF: (Print full name) _____

8. Height		9. Weight		10. Circumference-Chest		11. Circumf. Abdomen
Fl.	In.	Present	1 Yr. Ago	Insp.	Exp.	
12. Pulse Rate		(1)		(2)		(3)
13. Blood Pressure:		Systolic		Diastolic (Phase V)		
1st Reading						
2nd Reading						
3rd Reading						

On inquiry and examination is there evidence of:

	YES	NO
14. Present or past diseases or abnormalities of:	<input type="checkbox"/>	<input type="checkbox"/>
a. Brain, nervous system? (test reflexes; coordination).....	<input type="checkbox"/>	<input type="checkbox"/>
b. Eye, ears, nose, throat, teeth, gums?	<input type="checkbox"/>	<input type="checkbox"/>
c. Thyroid or lymph glands?.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdominal organs?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genito-urinary systems?.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Skin or skeletal structure?	<input type="checkbox"/>	<input type="checkbox"/>
15. Hernia? (If "Yes," describe)	<input type="checkbox"/>	<input type="checkbox"/>
16. Varicose veins or ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
17. Arteriosclerosis; other peripheral vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>
18. Presence of past diseases or abnormalities of heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
(If "Yes," complete questions 19a through g.).....	<input type="checkbox"/>	<input type="checkbox"/>

19. Urinalysis See note below	Albumin	Sugar

	YES	NO
a. Are you satisfied specimen is authentic?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you forwarding Specimen?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you completed with this exam:		
An EKG?	<input type="checkbox"/>	<input type="checkbox"/>
Blood Profile?.....	<input type="checkbox"/>	<input type="checkbox"/>
Other?		

DETAILS (REVERSE)

TO BE COMPILED BY MD ONLY

a. Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis?	<input type="checkbox"/>	<input type="checkbox"/>
b. Is there hypertrophy? (If "Yes," state degree)	<input type="checkbox"/>	<input type="checkbox"/>
c. Is there a murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>
Type: <input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic <input type="checkbox"/> Presystolic		
Quality: <input type="checkbox"/> Soft <input type="checkbox"/> Rough <input type="checkbox"/> Blowing		
Intensity: <input type="checkbox"/> Faint <input type="checkbox"/> Moderate <input type="checkbox"/> Loud		
Location: <input type="checkbox"/> Apex <input type="checkbox"/> Aortic <input type="checkbox"/> Pulmonic		
d. Is murmur constant?	<input type="checkbox"/>	<input type="checkbox"/>
e. Is murmur transmitted?	<input type="checkbox"/>	<input type="checkbox"/>
"Yes," where?		

f. EXERCISE TEST - 50 vigorous hops	Pulse Rate	Irregularities		Murmur	
		No. per minute	Present	Absent	Absent
Before exercise					
Immediately after					
3 minutes after					

g. PLEASE RECORD FINDINGS USING FOLLOWING SYMBOLS:

Position of apex beat.....

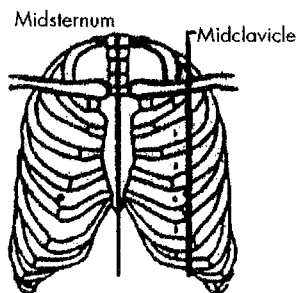
(_____ ins. or _____ cms. from midsternum in _____ interspace)

Murmur:

Area of distribution

Point of greatest intensity.....

Direction of transmission..... ➔



ExamOne Examiner

Please print name: _____ Signature _____ Date _____

Address _____ City _____ State _____ Zip _____

Office # _____