

**MEDICAL EXAMINER'S REPORT**

1. a. Proposed Insured's Name \_\_\_\_\_ b. Agent's Name \_\_\_\_\_

c. Describe type of identification used to verify Proposed Insured's identity: *(Photo ID Preferable)*

d. For: Life Insurance  Health Insurance  e. Type and amount of insurance applied for: \_\_\_\_\_ f. Are you related to Proposed Insured? Yes  No  g. How long have you known Proposed Insured? \_\_\_\_\_

2. What is Proposed Insured's:

a. Height? (in shoes) _____ ft. _____ in.	b. Weight? (clothed) _____ lbs.	c. Did you measure? Yes <input type="checkbox"/> No <input type="checkbox"/>	d. Did you weigh? Yes <input type="checkbox"/> No <input type="checkbox"/>	e. Change in weight during past year <input type="checkbox"/> Gain <input type="checkbox"/> Loss _____ lbs.	Cause _____
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8. a. Are there any hernias? ..... Yes  No   
 b. Any hemorrhoids? ..... Yes  No   
 9. Are you aware of additional medical history?  Yes  No

3. BLOOD PRESSURE: Record resting blood pressure under FIRST READING.  
 If systolic is more than 138 or diastolic (disappearance of all sound) is more than 88, take two additional readings, at rest, 5 minutes apart. Report all observations.

	FIRST READING	SECOND READING	THIRD READING
Systolic			
Diastolic			

10. URINALYSIS:

a.	Specific Gravity	Albumin	Sugar

4. PULSE:

	Rate	No. of Irregularities/Min.
At rest		
*Immediately after exercise		
*Two minutes after exercise		

b. MAIL SPECIMEN IN CONTAINER AND ENVELOPE PROVIDED IF:

- There are any abnormalities in specimen examined.
- There is hypertension or a history of hypertension.
- There is history of diabetes mellitus, G.U. disease, or urinary abnormalities.
- There is a family history of diabetes mellitus.
- The initial blood pressure exceeds 150/90.
- The age is over 55.
- The AMOUNT APPLIED FOR is over \$200,000 of Life Insurance and/or \$1,000 per month or more of Disability Income Insurance.

c.  Check here if urine specimen forwarded.

d. Is Proposed Insured in menstrual cycle? ... Yes  No

\*To be completed if:

- The Amount Applied For is more than \$200,000 of Life Insurance or \$1,000 per month or more of Disability Income Insurance.
- Pulse irregular or rate over 90 or under 60.
- Murmur present, or history of murmur or cardiotropic infection. (Also see No.6)  
 (Exercise should consist of at least 30 hops, or the equivalent; however, do not exercise if in your judgment it is contraindicated.)

5. HEART:

a. Apex beat is \_\_\_\_\_ centimeters from midsternal line in the \_\_\_\_\_ th interspace  
 (Locate Apex on Diagram) Yes  No

b. Is the heart enlarged?  Yes  No

c. Is there a murmur?  Yes  No   
 (If so, complete all parts of No. 6.)

11.  Check here if blood sample requested and forwarded.

12. Are any medications being taken? ..... Yes  No   
 (If yes, list them)

6. MURMUR:

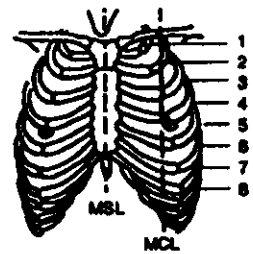
a. Timing	b. Intensity	c. Quality	d. Response to:	
<input type="checkbox"/> Systolic	<input type="checkbox"/> Faint (Gr. 1-2)	<input type="checkbox"/> Soft	Exercise	Respiration
<input type="checkbox"/> Presystolic	<input type="checkbox"/> Mod. (Gr. 3-4)	<input type="checkbox"/> Blowing	<input type="checkbox"/> Increase <input type="checkbox"/>	<input type="checkbox"/> Decrease <input type="checkbox"/>
<input type="checkbox"/> Diastolic	<input type="checkbox"/> Loud (Gr. 5-6)	<input type="checkbox"/> Rough	<input type="checkbox"/> Disappear <input type="checkbox"/>	<input type="checkbox"/>

e. In supine position does the murmur  
 Intensify?  Yes  No   
 Decrease?   
 Disappear?

f. Is murmur transmitted?  
 Yes  No

g. Location  
 Place an "X" at site of apex beat  
 Point of greatest intensity   
 Transmission

h. Your diagnosis or opinion?



7. SYSTEM EXAM: Have you found, after examination, any abnormality of:  
 (Circle applicable items and give details.)

a. Eyes, ears, nose, mouth, pharynx? .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(If vision or hearing markedly impaired, indicate degree and correction.)		
b. Skin (include scars); lymph nodes? .....	<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 (include 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"/>
i. Is there any evidence to suggest peripheral vascular disease? .....	<input type="checkbox"/>	<input type="checkbox"/>

Details of "Yes" answers (Identify item by number and letter.)

I certify that I have \_\_\_\_\_  A.M. \_\_\_\_\_  
 made this examination on \_\_\_\_\_ at \_\_\_\_\_  P.M. at  my office  individual's office  individual's home  other \_\_\_\_\_  
 and that the foregoing questions have been asked and the answers of the person examined recorded as stated.

Signature of Medical Examiner \_\_\_\_\_ M.D. Please print, type or rubber stamp your name and address. \_\_\_\_\_