

ExamOne

PHYSICAL MEASUREMENTS FORM

Insurance Company Name		City	State
Account Number	District or Agency	File or Policy Number	Name of Agent / #
Name of Applicant		Date of Birth	Social Security Number
Amount Applied for	Type of Policy (Life, Health, Disability, etc.)		

Height

(In Flat Shoes) _____ FT _____ IN

Physical Measurements

(Males Only)

Weight

(Clothed) _____ LBS

Inhale Exhale

Chest _____

Abdomen _____

Blood Pressure

(Both arms while seated)
(Two readings are recorded – none disregarded)
(If systolic over 140 or diastolic over 90 – Take 3rd and 4th readings after 10 minutes rest)

	RA	LA	Repeat RA	Repeat LA
Systolic	_____	_____	_____	_____
Diastolic	_____	_____	_____	_____

Pulse Rate

(At rest – Record for one full minute) _____ Per Min Any Irregularities # _____

Specimen Delivery

Lab
(Collected and sent to lab)

Urine **Venipuncture**
 Yes No Yes No

Fingerstick **Saliva Test**
 Yes No Yes No

If Urine Specimen Not Sent To

Albumin Sugar

If Specimen Is Being Sent To Lab – Indicate Lab
 LabOne C.R.L. Heritage Other: _____

Signature Of Technician _____

Date _____

Signature of Applicant _____

Date _____

Affix Address Stamp Here