

MEDICEXAMS PARAMEDICAL EXAMINATION

REPRESENTATIONS TO THE MEDICAL EXAMINER

Birth Date: _____

First Name	M.I.	Last Name	
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1. a.) Name and address of your personal physician. (If none, so state)

- b.) Date and reason last consulted?

- c.) What treatment or medication was given or recommended?

(If yes to questions 2-15 provide details in item 16 on next page)

2. Have you ever had or been treated for cancer or tumor? _____
3. In the last ten years, have you had, been treated for or received counseling for:
 - a) high blood pressure, chest pain or disorder of the heart or circulatory system? _____
 - b) diabetes or disorder of the glands, bone, blood or skin? _____
 - c) complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems? _____
 - d) hernia, hepatitis, or disorder of the liver, gall bladder, stomach, pancreas, spleen, intestines or rectum? _____
 - e) arthritis, rheumatism, or disorder of the joints, limbs, or muscle? _____
 - f) disorder or condition of the back, neck or spine? _____
 - g) allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? _____
 - h) epilepsy, stroke, dizziness, headache, or disorder of the brain or spinal cord? _____
 - i) disorder of the eyes, ears, nose or throat? _____
 - j) anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? _____
 - k) chronic fatigue syndrome, fibromyalgia, epstein barr virus or lyme disease? _____
4. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? _____
5. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus? _____
6. Medication/Drug History
 - a) Are you currently taking prescription medication? _____
 - b) Are you currently taking non-prescription medication? _____

(continued on next page)

- c) Have you ever regularly and repeatedly used stimulants, hallucinogens, narcotics or any other controlled substance other than as prescribed by a physician? _____
- d) Have you ever had or been advised to have counseling or treatment for alcohol or drug use? _____
- 7. Are you now pregnant? _____
If yes, expected delivery date: _____
- 8. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim? _____
- 9. Within the past five years, have you had a physical exam or check-up of any kind? _____
- 10. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests? _____
- 11. Other than previously stated in the past five years have you received medical advice from physicians, medical/mental health professionals, or other practitioners, and have you been a patient in a hospital, clinic, sanatorium, or other medical facility? _____
- 12. Do you participate in regular exercise? _____
If yes, describe type and frequency in section 16.
- 13. Do you smoke cigarettes _____, cigars _____, pipe _____?
If yes, how often? _____
- 14. Do you have a reason to believe that you are not in good health or decreased state of well being? _____
- 15. Do you, or any member of your family suffer from: diabetes, high blood pressure, heart disease, mental illness, or attempts of suicide? _____

	Age if living	Age if deceased	Cause of Death
Father			
Mother			
Brothers living ____ deceased ____			
Sisters living ____ deceased ____			

16. Details of "yes" answers. Identify and circle applicable question number and give detailed explanation. (If more space is required attach page to

Question #	Dates from-to	Condition, Treatment, and Results	Names of Physician(s), Hospital/Facility, and Addresses (city,state,zip)

(continued on next page)

Physical Exam:

- A. **Build:** 1. Height ____ ft ____ in
2. Weight _____ lbs
3. Chest at inspiration ____ in
Chest at expiration ____ in
4. Umbilicus ____ in
Did you measure? _____
Did you weigh? _____
- B. **Pulse:** 1. Rate at rest? _____ bpm
2. Any irregularities? _____
- C. **Blood Pressure** (if above 140/90 record additional readings)
systolic ____ / diastolic ____

I hereby represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. All notations made by examiner shall be deemed accurate and admissible for the purpose(s) intended. Medic Exams reserves the right to non-accountability of misinformation on the part of the Applicant/Examined stated.

Examined at _____ on this ____ day of _____, 2____
(City and State) (Month) (Year)

Signature of Examiner **X** _____
Signature of Person Examined

Positive Identification by: Drivers License or State/Gov Issued ID - ID Type _____

License/ID # _____

Please fax a copy of the completed exam to 1-877-327-1072
Completed exams need to be faxed within 24hours of completion!
Any questions please call 888-567-6688 or email Lblue@medicexams.com