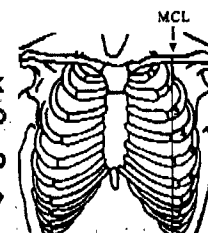


MEDICAL EXAMINER'S REPORT

10. a. Height (In Shoes) ft. in.		Weight (Clothed) lbs.		Males Only			(f) Genitourinary system (include prostate)? <input type="checkbox"/> YES <input type="checkbox"/> NO (g) Endocrine system (include thyroid and breasts)? <input type="checkbox"/> YES <input type="checkbox"/> NO (h) Musculoskeletal system (include spine, joints, amputations, deformities) <input type="checkbox"/> YES <input type="checkbox"/> NO
				Chest (Full Inspiration) lbs.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.	
b. Did you weigh?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Did you measure?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Is appearance unhealthy or older than stated age?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
11. Blood Pressure (Record ALL readings)							15. (a) Are there any hernias? <input type="checkbox"/> YES <input type="checkbox"/> NO (b) Are there any hemorrhoids? <input type="checkbox"/> YES <input type="checkbox"/> NO 16. Are you aware of additional medical history? <input type="checkbox"/> YES <input type="checkbox"/> NO (A confidential report may be sent to the Medical Director).
Systolic							
Diastolic 5th phase							
12. Pulse:		At Rest		After Exercise		3 Minutes Later	
Rate							
Irregularities per min.							
13. Heart: Is there any:							
Enlargement		<input type="checkbox"/> Yes <input type="checkbox"/> No		Dyspnea		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Murmur(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		Edema		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(describe below — if more than one, describe separately)							
		APEX		BASE			
Location		<input type="checkbox"/>		<input type="checkbox"/>			
Constant		<input type="checkbox"/>		<input type="checkbox"/>			
Inconstant		<input type="checkbox"/>		<input type="checkbox"/>			
Transmitted		<input type="checkbox"/>		<input type="checkbox"/>			
Localized		<input type="checkbox"/>		<input type="checkbox"/>			
Systolic		<input type="checkbox"/>		<input type="checkbox"/>			
Presystolic		<input type="checkbox"/>		<input type="checkbox"/>			
Diastolic		<input type="checkbox"/>		<input type="checkbox"/>			
Soft (Gr. 1-2)		<input type="checkbox"/>		<input type="checkbox"/>			
Mod. (Gr. 3-4)		<input type="checkbox"/>		<input type="checkbox"/>			
Loud (Gr. 5-6)		<input type="checkbox"/>		<input type="checkbox"/>			
After exercise:							
Increased		<input type="checkbox"/>		<input type="checkbox"/>			
Absent		<input type="checkbox"/>		<input type="checkbox"/>			
Unchanged		<input type="checkbox"/>		<input type="checkbox"/>			
Decreased		<input type="checkbox"/>		<input type="checkbox"/>			
Indicate							
		Apex by		X			
		Murmur area by		○			
		Point of greatest intensity by		○			
		Transmission by		↓			
							
For comments and your impression?							
14. Is there on examination any abnormality of the following: YES NO							
(Circle applicable items and give details.)							
(a) Eyes, ears, nose, mouth, pharynx?						<input type="checkbox"/> YES <input type="checkbox"/> NO	
<small>(If vision or hearing markedly impaired, indicate degree and correction)</small>							
(b) Skin (incl. scars), lymph nodes, varicose veins or peripheral arteries?						<input type="checkbox"/> YES <input type="checkbox"/> NO	
(c) Nervous system (include reflexes, gait, paralysis)?						<input type="checkbox"/> YES <input type="checkbox"/> NO	
(d) Respiratory system?						<input type="checkbox"/> YES <input type="checkbox"/> NO	
(e) Abdomen (include scars)?						<input type="checkbox"/> YES <input type="checkbox"/> NO	
Urinalysis: Specify Gravity		Albumin		Sugar		Send Specimen To Home Office If:	
Is specimen being sent to Home Office?		<input type="checkbox"/> Yes <input type="checkbox"/> NO				Requested by agent. Age 60 or over. Albumin or sugar is found Blood pressure is high. History of G. U. disease.	
I have carefully examined _____ this _____ day of _____, 19____, at _____ o'clock _____ A.M. / P.M.							
Examination was made in private at		<input type="checkbox"/> my office		<input type="checkbox"/> residence of proposed insured		<input type="checkbox"/> place of business of proposed insured	
Examined at _____ (Town) _____ (County) _____ (State)							
NB — THIS EXAMINATION MUST BEAR DATE OF DAY WHEN ACTUALLY MADE AND UNDER NO CIRCUMSTANCES ANY OTHER.							
Name of Agent Requesting Examination _____				After signing, print, type or rubber stamp name and office address below			
				Name _____			
				Street and Number _____			
				City, State and Zip Code _____			
Must Be Furnished Under Authority Of Law (where applicable)		Individual Practitioners		— Soc. Sec. No.		All Others — Employer I.D. No.	