



Basic Exam

Company _____

Name of Applicant _____ D.O.B. _____ Sex: Male Female

Address _____
Street City/Town State Zip Code

Family Physician _____ Date & Reason Consulted _____
Street City/Town State Zip Code

Address _____
Street City/Town State Zip Code

Treatment and/or Medication Prescribed? Yes No (If Yes, give details in #8 Remarks Section)

- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| 1. Have you ever consulted any medical practitioner for, or so far as you know, ever been treated for: | | |
| A. Any disorder of eyes, ears, nose or throat, including speech impairment or loss of sight? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Any disease of the lungs or respiratory tract such as tuberculosis, emphysema, pleurisy, asthma, hayfever, spitting blood, or persistent hoarseness or coughing? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Any disorder of the heart or blood vessels, e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Any disorder of the prostate, bladder, kidneys or genito-urinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Any brain or nervous system disorder, e.g., epilepsy, convulsions, fainting or loss of consciousness, mental illness, constant nervousness or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Any alcoholism or excessive use of alcohol or any drug habit? Any treatment or hospitalization? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Any impairment of function, or loss of hand, arm, shoulder, foot, leg or hip, or back disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever: | | |
| A. Had a surgical operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Been told to have an operation that wasn't performed? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Had any diagnostic procedures, e.g. x-ray, electro-cardiogram? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Lived with someone who has had T.B. in the last 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Had a weight change in the past year? If yes, reason? (List below) | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Had a physical or mental condition that caused you to be deferred, rejected or discharge from the armed forces? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Ever applied for or received any pension or benefits for sickness, disability or accident? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| 3. Other than previously stated, as far as you know, have you in the last 5 years: | | |
| A. Had any illness, disease or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Been admitted to, or been advised to enter, a hospital or sanitarium, etc. | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Consulted any medical practitioner for any reason (including check-ups?) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Any reason to feel you are not in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Are you taking any medication or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. For women only: | | |
| A. Are you pregnant? If yes, please give month of pregnancy, any previous pregnancies, and any complications of those pregnancies, if any. (list below) | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Any disorder of the breasts or female organs? | <input type="checkbox"/> | <input type="checkbox"/> |

5. A. Family History

Family Record	Age if Living	Condition of Health if not "Good," give details	Age At Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

- | | | |
|--|--------------------------|--------------------------|
| B. Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you participate in regular exercise? If yes, describe type and frequency. (list below) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Smoking Habits:
Do you smoke cigarettes?
If yes, packs per day (list below)
If non-smoker, did you ever smoke cigarettes?
If yes, for how long, packs per day and when did you quit? (list below) | <input type="checkbox"/> | <input type="checkbox"/> |

8. Remarks: Please give full details for any questions above answered "Yes".

Question #	Dates and Duration	Physician's Name, Hospital or Company, Address, City, State and Zip Code Nature of Condition, Treatment, Results, Reasons and Other Information

