Mailing Address:
P.O. Box 10431
Des Moines, IA 50306-0431

Principal Life Insurance Company

Medical Questionnaire

Print full name of Proposed Insured | Date of Birth (Month/Day/Year)

		Yes	No
1.	In the last ten years, have you had, been treated for or been diagnosed as having:		
	a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, anemia, or any other disease or disorder of the heart or blood vessels?	☐	☐
	b. cancer or a tumor, cyst or growth?	☐	☐
	c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system?	☐	☐
	d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system?	☐	☐
	e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder?	☐	☐
	f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract?	☐	☐
	g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system?	☐	☐
	h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system?	☐	☐
	i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, fibromyalgia, or any other disease or disorder of the bones, joints, or muscles?	☐	☐
	j. any disease or disorder of the eyes, ears, nose, throat or skin?	☐	☐
2.	(DI Only) Are you currently pregnant or have you had complications of pregnancy in the last ten years?	☐	☐
3.	In the last ten years, have you had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	☐	☐
4.	In the last ten years:		
	a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question?	☐	☐
	b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question?	☐	☐
5.	Are you taking or have you been advised to take any medication or treatment not provided in response to a previous question?	☐	☐
6.	Have you lost more than 10 lbs. in the last year? If yes, _____ lbs./kgs. Indicate reason. _______________________	☐	☐
7.	a. Has either of your natural parents lived to at least age 60?	☐	☐
	b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death)	☐	☐
8.	Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, provide details)	☐	☐

DETAILS TO QUESTIONS 1-8

For "yes" answers to questions 1-6 include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address. (if additional space needed, attach a separate page that is completed, witnessed, signed, and dated)

Quest. #	

Medical Questionnaire, continued

9. Who is your Primary Physician? ☐ None

a. Name | Phone Number

Street | City | State | Zip

b. Date last seen, reason and details

I have read the statements and answers recorded above; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Signature of Proposed Insured	Date	Signed at (City, State)	Signature of Witness/Title
X			X

PHYSICAL MEASUREMENTS RECORDED BY EXAMINER

10. a. Height (in Shoes) feet _______ in. _______ ; or cm ________
b. Weight (Clothed) pounds _______ ; or kg _______
c. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No
d. Chest (Full Inspiration) in./cm. ________
Chest (Forced Expiration) in./cm. ______
Abdomen, at Umbilcus in./cm. ________

11. Blood Pressure in sitting position:

	First Reading	Second Reading	Third Reading
Systolic/ Diastolic			

12. Pulse:

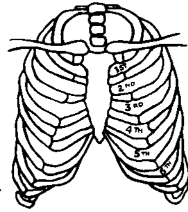
	At Rest
Rate	
Irregularities per min.	

13. Heart: is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below)
Location

☐ Constant
☐ Inconstant
☐ Transmitted
☐ Localized
☐ Systolic
☐ Diastolic
☐ Soft (Gr. 1-2)
☐ Mod. (Gr. 3-4)
☐ Loud (Gr. 5-6)

Indicate:
Apex by X
Murmur area by ◌
Point of greatest intensity by ○
Transmission by ➡



14. Is there any abnormality of the following (circle applicable items and give details) on examination:

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (incl. scars); lymph nodes; varicose veins; peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
15. (a) Are there any hernias?	☐	☐
(b) Any hemorrhoids?	☐	☐
16. Are you aware of additional medical history?	☐	☐

Give details to "Yes" answers:

Name of agent soliciting application: ____________________

Examination made at: ☐ Examiner's Office ☐ Applicant's Home ☐ Other ____________

Examiner (print name) ____________________ M.D./D.O./Para Med.

Exam Company Name ____________________

Exam Company Address ____________________

Signature of Examiner X ____________________

Send exam to Home Office only.

Principal Financial Group

Mailing Address:
P.O. Box 10431
Des Moines, IA 50306-0431

Principal Life Insurance Company

Medical Questionnaire

Print full name of Proposed Insured | Date of Birth (Month/Day/Year)

Quest. #	Include dates and details as requested.

Signature of Proposed Insured	Date	Signed at (City, State)	Signature of Witness/Title
X			X