

**Insurance Application Medical History — Part II**

**Proposed Insured's name:**

(first) \_\_\_\_\_ (full middle) \_\_\_\_\_ (last) \_\_\_\_\_ Birthdate: \_\_\_\_\_

How was the identity of Proposed Insured established? \_\_\_\_\_ Photo I.D.  Yes  No

1. a. Name and address of your personal physician? (If none, so state) \_\_\_\_\_  
 b. Date and reason last consulted? \_\_\_\_\_  
 c. What treatment was given or medication prescribed? \_\_\_\_\_

You do not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Medical Authorization near the signature line of this Insurance Application Medical History for a definition of "Emergency Medical Personnel".

	Yes	No	
2. Have you in the past 10 years been treated for:			<b>Details of "Yes" answers. Identify Question Number:</b> Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities. An additional sheet of paper may be attached if necessary.
a. Disorder of eyes, ears, nose or throat? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
b. Multiple sclerosis, Parkinson's disease, dementia, ALS; fainting, convulsions, dizziness; paralysis, memory loss or stroke; mental, nervous, anxiety, depression or emotional condition? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
c. Tumor, cancer or lymph node disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
d. Persistent hoarseness or cough, shortness of breath, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
e. Congestive heart failure (CHF), cardiomyopathy, chest pain, heart attack, heart palpitation, atrial fibrillation, high blood pressure, rheumatic fever, heart murmur or other disorder of the heart, heart valves, or blood vessels? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
f. Liver disorder, yellow jaundice or hepatitis? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
g. Stomach or intestinal bleeding, ulcer, colitis, inflammatory bowel disease, diverticulitis, recurrent indigestion, or other disorder of the stomach, pancreas, or intestines? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
h. High blood sugar, thyroid disorder or diabetes? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
i. Sugar, protein or blood in urine; any disorder of the kidney, bladder, prostate or reproductive organs? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
j. Arthritis, gout, rheumatism, or lupus; fibromyalgia, chronic fatigue syndrome or other connective tissue disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
k. Sciatica, neuropathy, disorder of the muscles or bones, including the spine, back, neck, or joints? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
l. Disorder of the skin; allergies? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
m. Anemia, bleeding or clotting disorder, or other blood/bone marrow disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
n. Excessive use of or dependency on alcohol or drugs, including prescription pain medications? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
3. Been diagnosed or received treatment by a member of the medical profession for AIDS (Acquired Immune Deficiency) or ARC (AIDS-Related Complex)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you ever used marijuana, cocaine, heroin, or amphetamines? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you had any change in weight in the past year? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
6. <b>Other than above</b> , have you within the past 5 years:			
a. Had any mental or physical disorder not listed above? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had a checkup, consultation, illness, injury, or surgery? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
c. Been a patient in a hospital, clinic or other medical facility? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
d. Had an electrocardiogram, treadmill stress test, thallium stress test, angiogram, echocardiogram, MRI or CT scan? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
e. Had an x-ray, mammogram, ultrasound, or other diagnostic test? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been advised to have any diagnostic test or surgery which has not been completed? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you ever used tobacco or nicotine in any form? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, what is/was used? _____			
b. What amount? _____			
c. Date last used? _____			
8. Are you currently using any prescription medication? . . . . . (list medications and reason they are prescribed in <b>details</b> section)	<input type="checkbox"/>	<input type="checkbox"/>	

9. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?		<b>Yes</b>	<b>No</b>
10. Is there any family history of cancer, diabetes, heart, kidney or neurologic disease? .....		<input type="checkbox"/>	<input type="checkbox"/>
	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			
No. Living			
No. Dead			

I have read the statements and answers in this Insurance Application Medical History. I declare to the best of my knowledge and belief, they are complete and true. I understand this Insurance Application Medical History will become part of my application for insurance. It will be attached to and made a part of any policy issued.

**Signature of Proposed Insured** \_\_\_\_\_ **Date** \_\_\_\_\_ **Signature of Witness (Examiner)** \_\_\_\_\_  
**X** \_\_\_\_\_ **X** \_\_\_\_\_

**Medical Examiner's Report**

**11. FOR EXAMINER USE ONLY**

**Height** \_\_\_\_\_ feet \_\_\_\_\_ inches **Weight** \_\_\_\_\_ lbs.  
**Pulse Rate** (1st) \_\_\_\_\_ Minute \_\_\_\_\_ (2nd) \_\_\_\_\_ Minute \_\_\_\_\_  
**Blood Pressure** (Systolic/Diastolic) 1st \_\_\_\_\_ 2nd \_\_\_\_\_ 3rd \_\_\_\_\_

12. Heart: Is there any: \_\_\_\_\_  
Murmur(s)  Yes  No  
Dyspnea  Yes  No  
Edema  Yes  No  
(Describe below — if more than one, describe separately)

Location	Apex	Base	Indicate:
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Apex by <b>X</b>
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by <b>⊙</b>
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by <b>○</b>
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>	Transmitted <b>→</b>
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"/>	
Thrill	<input type="checkbox"/>	<input type="checkbox"/>	

Give comments and your impression.

If murmur is present, is it altered by exercise?  Yes  No

13. Is there on examination any abnormality of the following: (Circle applicable items and give details.) **Yes No**

a. Eyes, ears, nose, mouth, pharynx? .....

b. Skin (incl. scars); lymph nodes; thyroid; or peripheral arteries? .....

c. Nervous system (include reflexes, gait, atrophy)? .....

d. Respiratory system? .....

e. Abdomen (include scars)? .....

f. Musculoskeletal system (include spine, joints, deformities)? .....

14. Are you aware of additional medical history? .....

(A confidential report may be sent to the Medical Director)

I certify that I have examined the Proposed Insured designated on the reverse side hereof; and that the answers and statements of the Proposed Insured on the Medical History on other side of this sheet are exactly as made by the Proposed Insured to me, and that said Medical History was signed by the Proposed Insured in my presence.

Signature of Medical Examiner \_\_\_\_\_

**Notice:**  
RiverSource Life Insurance Company has adopted a "usual, customary, reasonable and prevailing" fee schedule for professional services. Please include a statement indicating your fee for this examination. (Paramedical Examiners: Submit monthly billing.)