DESERET MUTUAL
BENEFIT ADMINISTRATORS

Paramedical Exam

Name of Applicant _____ D.O.B._____ Sex: Male ❑ Female ❑
Address:_____
Street City/Town State Zip Code

Personal Physician:_____ Date & Reason Last Consulted:_____
Address:_____
Street City/Town State Zip Code

1. Treatment and/or Medication Prescribed or Refilled: Yes ❑ No ❑
(If yes, provide details in # 7, remarks section)

		Yes	No
2.	Have you ever consulted a medical practitioner, or so far as you know, been treated for any:		
A.	Disorder of the eyes, ears, nose or throat?	❑	❑
B.	Cancer, tumor, cyst or any other malignant disorder?	❑	❑
C.	Disorder of the heart or blood vessels (e.g. heart attack, chest pain, elevated blood pressure, arrhythmia, palpitations, stroke, transient ischemic attack, blood clot, etc.)?	❑	❑
D.	Disorder of the brain or nervous system (e.g. mental illness, seizure, fainting or loss of consciousness, severe headaches, tremors, etc.)?	❑	❑
E.	Disorder of the lungs or respiratory tract (e.g. asthma, emphysema, COPD, tuberculosis, shortness of breath, bronchitis, pneumonia, etc.)?	❑	❑
F.	Disorder of the endocrine system (e.g. diabetes, thyroid condition, pituitary disorder, etc.)?	❑	❑
G.	Disorder of the joints, bones or muscles (e.g. arthritis, gout, fibromyalgia, myositis, osteopathy, etc.)?	❑	❑
H.	Disorder of the gastrointestinal system (e.g. stomach, liver, intestines, colon, pancreas, etc.)	❑	❑
I.	Blood disorder (e.g. anemia, clotting, immune system, platelets, polycythemia, etc.)?	❑	❑
J.	Disorder of the kidneys, prostate, urinary bladder or reproductive system (e.g. nephritis, renal failure, prostatic hypertrophy, sugar/albumin/pus in urine, etc.)?	❑	❑
K.	Any surgical procedure?	❑	❑
L.	Disease or disorder not already identified?	❑	❑

		Yes	No
3.	Have you ever used or consumed any of the following:		
A.	Tobacco or nicotine (in any form)? If yes, list: type, amount per day, duration of use.	❑	❑
B.	Alcoholic beverages? If yes, list: quantity and frequency.	❑	❑
C.	Narcotics, stimulants, sedatives, hallucinogens?	❑	❑
4.	As far as you know and aside from any reasons previously indicated, have you in the last 5 years:		
A.	Had or been advised to have surgery or any other diagnostic study (e.g. X-ray, electrocardiogram, CT scan, MRI, angiogram, etc.)?	❑	❑
B.	Been admitted to or advised to enter a hospital, sanitarium, etc.?	❑	❑
C.	Taken any medications or drugs?	❑	❑
D.	For any reason, consulted a medical practitioner (including check-ups)?	❑	❑
5.	For females only:	❑	❑
A.	Any disorder of the breasts or reproductive organs?	❑	❑
B.	History of pregnancy? If yes, list: dates and any complications.	❑	❑
6.	Family history:		
A.			

	Age (if living)	Current health status	Age at death	Cause of death
Mother				
Father				
Brothers				
Sisters				

B.	Family history of cancer, diabetes, heart condition, hypertension, kidney condition, mental illness or suicide?	❑	❑

7. Remark any 'Yes' responses below:

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

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(Continued)

8. Blood pressure:

	1	2	3
Systolic			
Diastolic			

9. Pulse:

Rate:_____ Irregularities:_____

10. Measurements:

Height (w/out shoes) _____ Did you measure? Yes ❑ No ❑

Weight (lbs.) _____ Did you weigh? Yes ❑ No ❑

Any weight change in the past year? Yes ❑ No ❑
(If yes, provide details)

Males only: Chest expanded: _____ Chest contracted: _____ Abdomen at umbilicus: _____

11. Urinalysis: Albumin: _____ Glucose: _____

7. Remarks *(continued- use Additional Remarks page if necessary)*: _____

I declare that all information contained within this Paramedical Exam is, to the best of my knowledge, true, correct and recorded in its entirety by the examiner. I understand that this information will be used to help determine eligibility for coverage and that any falsification, omission or misstatement may be grounds to void the coverage. I, the applicant, authorize the release of this information to Deseret Mutual and the company contracted to provide this paramedical service. I, the applicant, authorize any physician, hospital official, or person who has or may attend or examine or who may be consulted by me to disclose any knowledge or information acquired to Deseret Mutual. I, the applicant, waive any action for the release of this or any other protected health information to those authorized above.

_____ _____

Signature of applicant | Signature of examiner

_____ _____

Printed name of applicant | Printed name of examiner

Date: MM/DD/YYYY_____ Date: MM/DD/YYYY_____

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Additional Remarks

Name of Applicant:_____ D.O.B._____

Exam date:_____

Remarks *(continued from exam – include question #)*:_____

Signature of applicant

Signature of examiner

Printed name of applicant

Printed name of examiner

Date: MM/DD/YYYY_____ Date: MM/DD/YYYY_____