APPS PARA MEDICAL SERVICES

Examined for _____

Insurance Company Policy

Name of Agent_____ No:_____

Type of Insurance: Life ☐ Health ☐ Other ☐ _____

Proposed Insured: _____ Birth Date: _____

First Name M. I. Last Name Month/Day/Year

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? _____

		Yes	No
2.	Have you ever been treated for or ever had any known indication of:		
	a. Disorder of eyes, ears, nose, or throat?	☐	☐
	b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
	c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
	d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐
	e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
	f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
	g. Diabetes; thyroid or other endocrine disorders?	☐	☐
	h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
	i. Deformity, lameness or amputation?	☐	☐
	j. Disorder of the skin or lymph glands, unexplained fevers, AIDS or immune deficiency disease, cyst, tumor or cancer?	☐	☐
	k. Allergies, anemia or other disorder of the blood?	☐	☐
	l. Excessive use of alcohol, tobacco, or any habit forming drugs?	☐	☐
3.	Are you now under observation or taking treatment?	☐	☐
4.	Have you had any change in weight in the past year?	☐	☐
5.	*Other than above*, have you within the past 5 years:		
	a. Had any mental or physical disorder not listed above?	☐	☐
	b. Had a checkup, consultation, illness, injury, surgery?	☐	☐
	c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
	d. Had electrocardiogram, X-ray, other diagnostic test?	☐	☐
	e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
6.	Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
7.	Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
8.	Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	☐	☐

DETAILS of "YES" answers. (IDENTIFY QUESTION NUMBER. CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

	Age if living	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living _____			
No. Dead _____			

9. Females only	Yes	No
a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts?	☐	☐
b. To the best of your knowledge and belief are you now pregnant?	☐	☐

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

Dated at _____ this _____ day of _____ , _____

Witness _____ _____

(Signature of Examiner) (Signature of Proposed Insured)

10a. Height (In Shoes ___ ft. ___in.	Weight (Clothed) _____ lbs.	MALES ONLY: Chest (Full Inspiration) _____ in.	Chest (Forced Expiration) _____ in.	Abdomen, at Umbilicus _____ in.	Details of "Yes" answers. (Identify item.)

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic 4th phase			
Diastolic 5th phase			

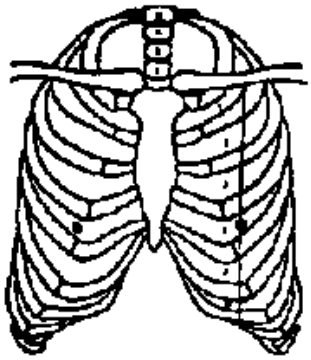
12. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

13. Heart: Is there any
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below – if more than one, describe separately)

Location

Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
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 O
Transmission by →



After Exercise:
Increased ☐ ☐
Absent ☐ ☐
Unchanged ☐ ☐
Decreased ☐ ☐

For comments and your impression:

14. 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; varicose veins or peripheral arteries? (*If vision or hearing markedly impaired, indicate degree and correction*.)	☐	☐
(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? ☐ Yes ☐ No Any hemorrhoids?	☐	☐
16.	Does proposed insured smoke? If yes, give details	☐	☐
17.	Are you aware of additional medical history?	☐	☐

Urinalysis: Specific Gravity	Albumin	Sugar	Are you related by blood or marriage to proposed insured? ☐ Yes ☐ No
Is specimen being sent to lab ☐ Yes ☐ No			

I certify that I have carefully examined _____ of _____ (Address)
in private at ☐ my office ☐ his place of business ☐ his home this _____ day of _____, _____ at _____ A.M./P.M.
Signature of Examiner_____ Address _____