Basic Exam

Company: _____

_____

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

Address: _____ (Street) _____ (City/Town) _____ (State) _____ (Zip Code)

Family Physician: _____ Date & Reason Consulted _____

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?	☐	☐
B. Any disease of the lungs or respiratory tract such as tuberculosis, emphysema, pleurisy, asthma, hayfever, spitting blood, or persistent hoarseness or coughing?	☐	☐
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?	☐	☐
D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis?	☐	☐
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?	☐	☐
F. Any brain or nervous system disorder, e.g., epilepsy, convulsions, fainting or loss of consciousness, mental illness, constant nervousness or severe headaches?	☐	☐
G. Any alcoholism or excessive use of alcohol or any drug habit? Any treatment or hospitalization?	☐	☐
H. Any impairment of function, or loss of hand, arm, shoulder, foot, leg or hip, or back disorder?	☐	☐
I. Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema?	☐	☐
2. Have you ever:		
A. Had a surgical operation?	☐	☐
B. Been told to have an operation that wasn't performed?	☐	☐
C. Had any diagnostic procedures, e.g. x-ray, electro-cardiogram?	☐	☐
D. Lived with someone who has had T.B. in the last 2 years?	☐	☐
E. Had a weight change in the past year? If yes, reason? (List below)	☐	☐
F. Had a physical or mental condition that caused you to be deferred, rejected or discharge from the armed forces?	☐	☐
G. Ever applied for or received any pension or benefits for sickness, disability or accident?	☐	☐

	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?	☐	☐
B. Been admitted to, or been advised to enter, a hospital or sanitarium, etc.	☐	☐
C. Consulted any medical practitioner for any reason (including check-ups?)	☐	☐
D. Any reason to feel you are not in good health?	☐	☐
E. Are you taking any medication or drugs?	☐	☐
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)	☐	☐
B. Any disorder of the breasts or female organs?	☐	☐

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				

	YES	NO
B. Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide?	☐	☐
6. Do you participate in regular exercise? If yes, describe type and frequency. (list below)	☐	☐
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)		

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

Basic Exam (Continued)

9. Pulse _____ per/minute ☐ Regular ☐ Irregular

Number of Irregularities, if any _____

10. Blood Pressure

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic			

Blood Pressure: Record 1 reading, if systolic over 140 or diastolic over 90, take second and third readings after 10 minutes of rest.

11. Height _____ (without shoes)

Weight _____

12. Urinalysis (Dipstick)

Glucose _____

Albumin _____

13. Measurements (Males Only)

Chest at full inspiration _____

Chest at forced expiration _____

Abdomen at umbilicus _____

14. Did you weigh? ☐ Yes ☐ No

Did you measure? ☐ Yes ☐ No

15. Obvious abnormalities:

16. Remarks:

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to the APPS-PORTAMEDIC Examiner is correctly recorded, complete and true, and I agree that the Company, believing them to be true, shall rely and act upon them accordingly.

Dated at _____ on _____ 19 _____

Witnessed by _____
APPS-Portamedic Examiner

Signature of Person Examined _____

APPS-PORTAMEDIC Branch Address:

APPS - PORTAMEDIC®
One Jericho Plaza
Jericho, NY 11753

Health Survey Information Authorization

I hereby authorize the release of this medical information to APPS-PORTAMEDIC and my Employer ☐ Prospective Employer ☐ Other ☐

Signature of Applicant Date

Signature of Witness/Examiner Date

Please Print Name of Applicant

Please Print Name of Witness/Examiner

This is a non-state specific generic exam form.

INSURER _____

ADDRESS _____

_____

"NOTICE AND CONSENT FOR HIV-RELATED BLOOD TESTING"

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test results. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

"Pre-Testing Considerations"

Many public health organizations have recommended that before taking an HIV-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

"Meaning of Positive Test Result"

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implication of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

"Confidentiality of Test Results"

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

"Notification of Test Result"

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do no designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

"Consent"

I have read and I understand this Notice and Consent for HIV-Related Blood Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____

Applicant Signature of Applicant's Parent/Guardian

_____ _____

Address Date Signed

AC 29 397

DISTRIBUTION: WHITE/HOME OFFICE - CANARY/APPLICANT - PINK/MEDICAL EXAMINER

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