# Medical History Questionnaire
# Group Medical Underwriting

**Minnesota Life Insurance Company** - A Securian Company
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MINNESOTA LIFE

| Proposed insured's name (last, first, middle) | Date of birth |
|---|---|
| | |

| | YES | NO |
|---|---|---|
| 1. A. Have you smoked cigarettes in the past 12 months? *(If yes, complete the table below.)* | ☐ | ☐ |
| B. Have you ever smoked cigarettes? *(If yes, complete the table below.)* | ☐ | ☐ |

| Current smoker | Past smoker | Packs per day | Date last cigarette smoked (mo., day, yr.) |
|---|---|---|---|
| ☐ | ☐ | | |

| | | |
|---|---|---|
| C. Have you used tobacco or nicotine of any kind, other than cigarettes, in any form, in the last 12 months? *(If yes, complete the table below.)* | ☐ | ☐ |
| D. Have you ever used tobacco or nicotine of any kind, other than cigarettes, in any form*? (If yes, complete the table below.)* | ☐ | ☐ |

| What type | Current user | Past user | How much | Date of last use (mo., day, yr.) |
|---|---|---|---|---|
| | ☐ | ☐ | | |

| | | |
|---|---|---|
| 2. Are you taking or do you take any prescription or non-prescription medications or drugs? If so, please provide information below. | ☐ | ☐ |

3. Have you ever been treated, diagnosed or given medical advice by a member of the medical profession for:

| | | |
|---|---|---|
| A. Epilepsy; Alzheimer's; Huntington's; Parkinson's; Mild Cognitive Impairment (MCI); dementia; paralysis; sleep apnea; depression; stress disorders; anxiety disorders; or any other brain, nervous, mental, emotional or sleep disorder? | ☐ | ☐ |
| B. High blood pressure; chest pain; chest discomfort or tightness; heart attack; heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels? | ☐ | ☐ |
| C. Asthma; shortness of breath; bronchitis; pneumonia; emphysema; chronic cough; or any other lung or respiratory disorder? | ☐ | ☐ |
| D. Abdominal pain; ulcer; colitis; cirrhosis; hepatitis; recurrent diarrhea; intestinal bleeding; or any other disease of the liver, gallbladder, pancreas, stomach, or intestines? | ☐ | ☐ |
| E. Kidney stone; protein, sugar, blood or blood cells in the urine; or any disorder of the urinary tract, bladder or kidneys? | ☐ | ☐ |
| F. Disorder or abnormality of the prostate, uterus, ovaries, or breasts; pregnancy complication; testicular disease; genital herpes, syphilis, gonorrhea, or other sexually transmitted disease? | ☐ | ☐ |
| G. Diabetes; thyroid disorder; lymph node enlargement; skin disorder; or disorder of any other glands? | ☐ | ☐ |
| H. Cancer; tumor; or cyst? | ☐ | ☐ |
| I. Anemia, leukemia, or other blood disorder? | ☐ | ☐ |
| J. Back or neck pain; spinal strain or sprain; sciatica; arthritis; gout; carpal tunnel syndrome; or any bone, joint, or muscle disorder? | ☐ | ☐ |
| K. Disorder of the eyes, ears, nose or throat? | ☐ | ☐ |
| L. Any physical deformity or defect? | ☐ | ☐ |
| M. Any immune system diseases or disorders except those related to the Human Immunodeficiency Virus (HIV virus)? | ☐ | ☐ |
| N. Any chronic or recurrent fever, fatigue or viral illness? | ☐ | ☐ |


*Continue on next page*

| | YES | NO |
|---|---|---|
| 4. Have you been diagnosed by a member of the medical profession or tested positive for the Human Immunodeficiency Virus (HIV virus) or Acquired Immune Deficiency Syndrome (AIDS)? | ☐ | ☐ |
| 5. Do you consume alcoholic beverages? If yes, what kinds, how much and how often? | ☐ | ☐ |
| 6. Have you been advised to limit the use of alcohol or drugs; sought or received treatment, advice, or counseling for alcohol or drugs; or joined a group because of alcohol or drug use? | ☐ | ☐ |
| 7. Have you ever used cocaine, heroin, marijuana, barbiturates or other controlled substances except as prescribed by a physician? | ☐ | ☐ |
| 8. Other than above, have you in the past five years: | | |
| A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.) | ☐ | ☐ |
| B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility? | ☐ | ☐ |
| C. Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test? | ☐ | ☐ |
| D. Been advised to have any test, hospitalization, or surgery which was not completed? | ☐ | ☐ |
| E. Had a CT Scan, MRI, EEG or any other diagnostic test for fainting spells, convulsions, seizures, headaches, or dizziness? | ☐ | ☐ |

9. Family History: Make a note of diabetes, cancer, melanoma, stroke, heart, and kidney disease.

| | | Age(s) | Health History | | Age(s) | Cause of Death |
|---|---|---|---|---|---|---|
| Father | Living | | | Deceased | | |
| Mother | | | | | | |
| Siblings | | | | | | |
| Siblings | | | | | | |

10. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below. ☐ ☐

| Name | Phone number | |
|---|---|---|
| Street address | | |
| City | State | Zip code |
| Date last seen | Reason | |

***Give details of all yes answers,*** *including doctors' names, phone numbers, addresses and dates.*

**Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

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

| Proposed insured signature | Date |
| --- | --- |
| **X** | |

# Examiner's Report

A. 1. Height in shoes FT. IN. | 2. Weight clothed LBS. | 3. Did you weigh? ☐ Yes ☐ No | 4. Did you measure? ☐ Yes ☐ No

5. Weight change in past year? LBS. ☐ Gain ☐ Loss | Cause? | 6. Measure waist (relaxed) IN.

B. Cardiovascular Examination:

1. After careful examination, do you find any evidence of past or present disorder of heart or blood vessels or any sign of arteriosclerosis?
   ☐ YES ☐ NO
2. Blood Pressure
   If systolic reading is over 140 or diastolic is over 90, take a second reading at the end of examination. (record both readings)

| | 1st reading | 2nd reading |
|---|---|---|
| a. Systolic | _____ mm | _____ mm |
| b. Diastolic - 5th phase (Disappearance of sound) | _____ mm | _____ mm |

3. Examine heart before and after exercise (15 bends) in upright and recumbent positions. Do not exercise if contra-indicated.

| Pulse (seated) | At Rest | After Exercise | After 5 Min. |
|---|---|---|---|
| a. Rate per minute | | | |
| b. Irregularities per minute | | | |

C. 1. Is heart enlarged? ☐ Yes* ☐ No | 2. Is murmur present? ☐ Yes* ☐ No | ** If yes, please complete section H "Cardiac Exam"*

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

| | YES | NO |
|---|---|---|
| 1. Eyes, ears, nose, mouth or pharynx | ☐ | ☐ |
| After examining eye grounds, do you find evidence of disease? | | |
| Type _____ | | |
| Circle appropriate grade: 1, 2, 3, or 4 | | |
| 2. Skin, (include scars); lymph glands; varicose veins | ☐ | ☐ |
| 3. Nervous system (include reflexes, gait, paralysis) | ☐ | ☐ |
| 4. Respiratory system | ☐ | ☐ |
| 5. Abdomen (including scars) | ☐ | ☐ |
| 6. Genitourinary system (include prostate) | ☐ | ☐ |
| 7. Endocrine system (include thyroid and breasts) | ☐ | ☐ |
| 8. Musculoskeletal system (include spine, joints, amputations, deformities) | ☐ | ☐ |

E. Does this person impress you as being in normal health? ☐ ☐

*If no, explain:* _____

F. Urinalysis

| Specific gravity | Albumin | Sugar |
|---|---|---|
| | | |

Check appropriate box and send specimen only if:

- ☐ Requested by agent.
- ☐ Parent and/or sibling diabetic.
- ☐ History of renal disease.
- ☐ Abnormal findings on dipstick analysis.

G. 1. How long and how well have you known the applicant?

_____

2. Where was this examination made? _____
3. If requested, are you sending ☐ ECG, ☐ X-ray or
   ☐ Other test? _____

H. Cardiac Exam: *To be completed if abnormality of heart size or murmur is found.*

1. Describe the murmur(s) in terms of timing, loudness, location, character and transmission.

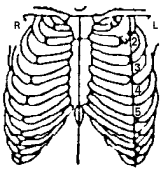
_____

_____

_____

_____

2. Locate:
   Apex by **X**
   Area of murmur by outline ⋰⋱
   Point of greatest intensity by ●
   Transmission by ➞




3. Your impressions? _____

DETAILS:

Name _____ M.D.

Address _____

City | State | Zip code

Signature

**X** _____ M.D.