

Policy number _____

The applicant does not have to disclose a test for bloodborne pathogens including Hepatitis B virus (HBV), Hepatitis C virus (HCV), and Human Immunodeficiency virus (HIV) 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 for a definition of "Bloodborne Pathogens", "Emergency Medical Services Person", "Source Individual" and "Significant Exposure".

1 Name of
Examinee

(First name, middle initial, last name)

2 Medical
Information

1. Physician Information

Physician last consulted

Name _____

Address _____

(street, city, state, ZIP)

Telephone number () _____ Date last seen ____/____/____

month day year

Reason last seen _____

Primary physician

Name _____

Address _____

(street, city, state, ZIP)

Telephone number () _____ Date last seen ____/____/____

month day year

Reason last seen _____

2. Has the person being examined ever used tobacco or other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? Yes No
(If Yes, provide date when last used and indicate all types of products.)

Product(s)

month year

3. Has the person being examined been diagnosed with or treated by a member of the medical profession for
- a. chest pain, or any disorder of the heart or blood vessels? Yes No
 - b. high blood pressure? Yes No
 - c. cancer, tumor, leukemia, melanoma, or lymphoma? Yes No
 - d. diabetes or high blood sugar? Yes No
 - e. mental or psychiatric illness? Yes No
 - f. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? Yes No
 - g. infection caused by the Human Immunodeficiency Virus (HIV)? Yes No
 - h. any sexually transmitted diseases? Yes No
 - i. asthma or any disorder of the lungs? Yes No
 - j. any disorder of the brain or the nervous system? Yes No
 - k. hepatitis or any disorder of the liver, stomach or intestines? Yes No
 - l. any disorder of the kidney or urinary tract? Yes No

4. Is the person being examined currently taking prescription medication? Yes No

5. Other than above, has the person being examined:
- a. been a patient in a hospital or other medical facility? Yes No

- b. in the last 5 years, had or been advised to have surgery, medical tests or diagnostic procedures such as ECGs, stress tests, X-rays, blood tests, urine tests, etc? Yes No

Primary Proposed Insured: _____

Policy Number: _____

Examiner's Confidential Report

Family Record

	Current Age or age at death	Year and Cause of Death
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
Sisters	_____	_____

A. Examination was done at:

Home Business My office

B. Time of day examined _____ AM _____ PM.

C. Height _____ ft. _____ in. Did you measure? Yes No

D. Weight (in clothes) _____ lbs. Did you weigh? Yes No

E. Blood pressure

	Systolic	Diastolic	Arm	Time Taken (Include AM/PM)
1st reading:	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right	_____
2nd reading:	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right	_____
3rd reading:	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right	_____

Always record three blood pressure readings taken at intervals.
Mail us a urine specimen if systolic is over 140 or diastolic is over 90.

F. Pulse

At rest (seated)

Pulse rate per minute	Premature contractions No. per minute

- If lowest rate exceeds 100, repeat observations later in examination.
- Any irregularities other than premature contractions? *(If yes, describe below.)* Yes No

G. Are there any abnormalities of: (Record all details below)

- Eyes (*retinopathy, retinal changes*)? Yes No
- Blood vessels (pedal pulses, bruits)? Yes No
- Respiratory organs (including nose, throat and mouth)? Yes No
- Abdominal organs (including tenderness, scars, organomegaly, bruits)? Yes No
- Nervous system? Yes No

Note: Examine heart in upright, recumbent and left lateral recumbent positions.

H. Heart - any murmur present? Yes No
(If yes, give details below.)

1. Murmur details

- | | | |
|--|---|--|
| <input type="checkbox"/> Apical | <input type="checkbox"/> Basal | <input type="checkbox"/> Other |
| <input type="checkbox"/> Systolic | <input type="checkbox"/> Diastolic | |
| <input type="checkbox"/> Barely heard-Gr.1 | <input type="checkbox"/> Faint-Gr.2 | <input type="checkbox"/> Mod-Gr.3 |
| <input type="checkbox"/> Loud-Gr.4 | <input type="checkbox"/> Very loud-Gr.5 | <input type="checkbox"/> Loudest possible-Gr.6 |
| <input type="checkbox"/> Transmitted | <input type="checkbox"/> Localized | |

2. Effect of body position: _____


- 3a. Is heart enlarged?** Yes No
b. Any other abnormal cardiac findings? Yes No
(If either is yes, describe below.)


4. What is your diagnosis or opinion?

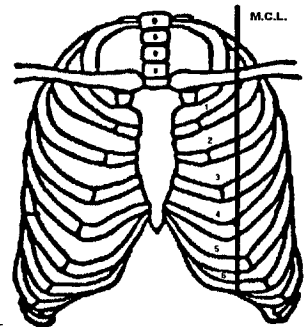
5. Mark position of apex; location of murmur(s) and transmission on diagram.

Position of apex beat **X**

Area of distribution of murmur 

Point of maximum intensity of murmur 

Direction of transmission of murmur 



I. Analysis of urine

- Are you mailing us a urine specimen? Yes No
(Mail a specimen, if required by instructions on cover.)
Albumin Yes No
Sugar Yes No
(If either is yes, mail us a portion of the urine examined.)

J. Female Only: Current menses? Yes No

K. Is the person examined your patient? Yes No
(If yes, and if any information was not disclosed, submit office records.)

L. Have you any information about this person not recorded elsewhere on this form relating to physical or mental impairment? Yes No

Give details of all yes answers to Questions F(2), G, H 3a-b, and L

I secured the required picture identification of the person examined. Yes No

I certify that on the date below, I examined the person named above. Yes No

Signature of examiner _____

Date of examination _____

(street, city, state, ZIP) _____