

Medical examination report

The costs of the examination have to be paid by the client

Name		Date of Birth		Proposal number	
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The above patient has applied to us for Private Medical Insurance and we would like you to carry out an examination on our behalf. This medical examination report is not to be completed by the spouse, the parents or the children of the examined person.

Part A must be filled out by a doctor, how the client is consulted.
Part B must be filled out by a doctor.

please send to:

A + E GmbH Versicherungsmakler
Rudolf-Diesel-Str. 16c
D – 53859 Niederkassel
Tel.: +49 (0)228/33 88 77 0
Fax: +49 (0)228/33 88 77 22

Medical History - Section A	Yes	No	If YES, please give full details of dates, severity, treatment, duration and results of investigations.
<p>Have you any physical defects of health impairments?</p> <p>Are you now or have you ever been under medical care, receiving tablets, medicines or injections for more than 1 week.</p> <p>Have you ever taken drugs other than for medical purposes? e.g. cocaine, heroin etc.</p>			
<p>Have you ever had any special or routine investigations? E.g. X-rays, cancer screening, electrocardiograms, blood or urine tests?</p> <p>Have you ever had or are you awaiting an operation or treatment at hospital, clinic or nursing home or are you attending out patient clinics or awaiting appointment?</p>			
<p>Have you ever had or do you now suffer from</p> <p>Asthma, bronchitis, pneumonia, pleurisy, tuberculosis, or any respiratory disorder?</p> <p>High blood pressure, chest pains, angina, coronary thrombosis, or any other heart or circulatory disorder?</p> <p>Rheumatic fever, gout, arthritis, backache or sciatica?</p> <p>Indigestion, gastric or duodenal ulcer, diarrhoea or any stomach or bowel disorder including colitis or PR bleeding?</p> <p>Any gall-bladder, liver disease including hepatitis, prostate, kidney, bladder or urinary disorder?</p> <p>Diabetes, anaemia or any blood or glandular condition?</p> <p>Stress, depression, anxiety, nervous illness chronic fatigue/debility or treatment by a psychiatrist or counsellor?</p> <p>Fainting, fits, epilepsy or any form of paralysis, or disease of the nervous system?</p> <p>Cancer, growths, lumps, cysts or tumours?</p> <p>Have you ever been diagnosed with polycystic ovary syndrome, endometriosis or any other disorder of the reproductive tract.</p> <p>Any illness not mentioned above including any disorder of the Ear/Nose/Throat, allergies, tropical or sexually transmitted diseases including AIDS?</p>			
<p>When, for any reason did you last visit your own or any doctor?</p> <p>How much time have you lost from work in the last 5 years? (Please give reason)</p> <p>Have you ever consulted any other doctor in the past 5 years or ever had a health screening?</p> <p>What are your daily habits in respect to:</p> <p>Exercise?</p> <p>Alcohol?</p> <p>Was your consumption ever higher? If yes please provide full details.</p> <p>Smoking?</p>			<p>Please indicate daily consumption</p>

If an ex-smoker, when did you stop?		
How many were you smoking?		

Medical History Section A - continued

Family History

IF LIVING			IF DECEASED	
	Present Age	State of Health	Age at Death	Precise Cause of Death
Father				
Mother				
Brothers				
Sisters				

Declaration I declare that the above answers are, to the best of my knowledge and belief, true and complete and I declare that this declaration shall be held to form part of the proposal for private health insurance on myself to the Company.

Signature of Proposed Insured _____ Date _____

Signature of Medical Examiner _____ Date _____

Section B – Report on physical examination of proposed insured

1. a) How long long have you known the proposed insured? b) Are you related? c) If you hold the medical records, for how many years do they go back?	a) b) c)																
2. Measurements (Taken by Examiner) a) Height without shoes b) Weight c) Chest measurement d) Has there been any variation in weight?(If yes Why?)	Cm _____ Kg _____ Full inspiration _____ CM Full Expiration _____ CM Yes _____ No _____																
3. Cardio-vascular system a) Please give the pulse rate/min. If irregular please state nature of irregularity, whether it decreases or disappears on exercise and the number of "Ectopics" per minute. b) Is there a heart murmur? If YES, give details c) Character and position of apex beat d) Is the heart enlarged? e) Blood pressure. If the first reading exceeds 140/90 please take two further readings after the applicant has been resting for 5 to 10 minutes.	a) rate/min _____ Is it regular? _____ b) Yes _____ No _____ i. Systolic _____ Diastolic _____ ii. At Apex _____ At Base _____ iii. Radiating to Base _____ To Axilla _____ iv. Grade of murmur _____ c) d) Yes _____ No _____																
	<table border="1"> <thead> <tr> <th>Systolic</th> <th colspan="2">Diastolic</th> <th>Pulse rate</th> </tr> <tr> <td></td> <th>4th phase</th> <th>5th phase</th> <td></td> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Systolic	Diastolic		Pulse rate		4th phase	5th phase									
Systolic	Diastolic		Pulse rate														
	4th phase	5th phase															

Section B - Continued			
f) Are the arterial pulses absent at the feet/ankles?		Yes ____	No ____
g) Is there any other evidence of arterial changes? (e.g. bruits, retinal changes)		Yes ____	No ____
h) Is there any leg oedema? If so bilateral/unilateral?		Yes ____	No ____
i) Are there any varicose veins? If so how severe and extensive are they?		Yes ____	No ____
4. Respiratory System	YES	NO	IF YES PLEASE GIVE FULL DETAILS
a) Is there any abnormality in the percussion note or breath sounds?			
b) Are there any other signs of past or present abnormality?			
c) Peak Expiratory Flow Rate, if available			
5. Digestive System			
a) Is there any palpable abnormality of the liver, spleen or other abdominal organs?			
b) Is a hernia present? (If YES, please state whether it requires support or surgical repair).			
6. Nervous system and Special Senses			
a) Is there any abnormality of the pupillary reactions or of the fundi?			
b) Is there any impairment of hearing/vision or the nasal tract?			
c) Current vision acuity			
d) Are the knee and ankle reflexes abnormal?			
e) Is there any restriction in the neck, shoulder or back movements?			
7. Genito-Urinary System			IF YES, PLEASE GIVE DETAILS OF THE DEGREE IF POSSIBLE
a) Does the urine contain:			
Albumen?			
Sugar?			
Sediments			
Bacteria?			
b) Any gynaecological problems, abnormal obstetric history, or diseases of the breast?			
Date and result of last cervical Smear/Mammogram			
8. General			
a) Is the build, appearance or behaviour unusual?			
b) Are there any signs of over indulgence in alcohol or the misuse of drugs?			
c) Are there any aspects to the proposer's life style which put him/her at the risk of contracting AIDS?			
d) Is there any condition likely to warrant medical treatment or surgical procedure in the foreseeable future?			
Signature of Examiner _____		Please print or stamp your name and address here.	
Date _____ Time of day _____			
Professional Qualifications _____			