

**Instructions:**

- Be sure to use the current and correct state specific National Life form.
- **Fees for Incomplete Exams will be charged back.**
- Pose each question exactly as printed.
- Check each 'YES' / 'NO' box - All questions must be answered.
- **Client must be weighed on a scale and measured.**
- Be sure to sign and date the form.
- Include the Agency name and number on all Lab ID slips.
- Paramedicals complete Pgs 1 & 2 and Pg 3 questions 18-27.
- Physicians complete the form in full.
- Non-Med Requirement: Pgs 1 & 2 completed by Agent.
- Deliver or mail the completed form.

1. Full Name of Proposed Insured \_\_\_\_\_

2a. Date of birth: \_\_\_\_\_ 2b. Place of birth: \_\_\_\_\_

3. Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Change in last year \_\_\_\_\_ lbs. Reason? \_\_\_\_\_

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to 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.

The term "**emergency medical personnel**" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who qualify for immunity under the good samaritan law.

If any question is answered 'Yes', give dates, details, results & include physician's name, address and phone number in Remarks on page 2.

4. a. Are you taking any medications currently? If so, what and why? \_\_\_\_\_  Yes  No  
 b. Have you ever applied for or received disability compensation from any source? \_\_\_\_\_  Yes  No
5. a. Within the past 5 years have you made the decision, or have you been advised by a physician or other medical professional, to reduce alcohol intake or have you attended meetings of an alcohol self-help group? (Do not provide the name of the self-help group.) \_\_\_\_\_  Yes  No  
 b. Except as prescribed by a physician, have you within the past 5 years used narcotic drugs, amphetamines, cocaine, barbiturates, tranquilizers, hallucinogens or marijuana? \_\_\_\_\_  Yes  No  
 c. Do you now use nicotine products in any form (including cigarettes, cigars, chewing tobacco, smokeless tobacco, pipe, "the patch", snuff or nicotine gum) or have you used nicotine products in any form within the last 24 months? \_\_\_\_\_  Yes  No
6. To the best of your knowledge, within the past 10 years, have you had:  
 a. Chest pain, heart murmur, rheumatic fever or anemia? \_\_\_\_\_  Yes  No  
 b. Habitual cough, asthma, emphysema or pleurisy? \_\_\_\_\_  Yes  No  
 c. Ulcer, jaundice or chronic indigestion? \_\_\_\_\_  Yes  No  
 d. Stroke, dizzy spells, epilepsy, convulsions, paralysis or unconsciousness? \_\_\_\_\_  Yes  No
7. To the best of your knowledge, within the past 10 years, have you received professional medical treatment or medical advice for disease or disorder of:  
 a. Heart, veins, arteries, blood or blood pressure? \_\_\_\_\_  Yes  No  
 b. Lungs or respiratory tract? \_\_\_\_\_  Yes  No  
 c. Esophagus, stomach, intestines, rectum, liver or gall bladder? \_\_\_\_\_  Yes  No  
 d. Kidney, bladder, prostate, genito-urinary organs, pelvic organs or breast? \_\_\_\_\_  Yes  No  
 e. Eyes, ears, nose or throat? \_\_\_\_\_  Yes  No  
 f. Brain, nervous system or headaches? \_\_\_\_\_  Yes  No  
 g. Spine, bones, muscles, joints, skin or glands? \_\_\_\_\_  Yes  No
8. To the best of your knowledge, within the past 10 years, have you been advised by a physician or other medical professional that you had:  
 a. Cancer, polyp or other tumor? \_\_\_\_\_  Yes  No  
 b. Gout, arthritis, rheumatism or back disorder? \_\_\_\_\_  Yes  No  
 c. High blood sugar or diabetes? \_\_\_\_\_  Yes  No  
 d. Albumin, sugar, protein or blood in the urine? \_\_\_\_\_  Yes  No  
 e. Renal colic or kidney stone? \_\_\_\_\_  Yes  No  
 f. Anxiety, depression, neurosis, psychosis, psychological problem or condition? \_\_\_\_\_  Yes  No
9. To the best of your knowledge, within the past 10 years have you received professional medical treatment or medical advice for disease or disorder of the immune system? \_\_\_\_\_  Yes  No
10. Have you had x-rays, electrocardiograms or other diagnostic tests within the past 5 years? If so, where? \_\_\_\_\_  Yes  No



# Medical Questionnaire (Continued)

## Instructions:

- Be sure to use the current and correct state specific National Life form.
- **Client must be weighed on a scale and measured.**
- **Fees for Incomplete Exams will be charged back.**
- Include the Agency name and number on all Lab ID slips

\_\_\_\_\_ (Proposed Insured) is being examined at the request of \_\_\_\_\_ (Agent)

18. Do you know the Proposed Insured? \_\_\_\_\_  Yes  No
19. Are you related to the Proposed Insured? \_\_\_\_\_  Yes  No
- 20. Does the Proposed Insured appear healthy?** \_\_\_\_\_  Yes  No
21. Are you the Proposed Insured's personal physician? \_\_\_\_\_  Yes  No
22. Do you have any knowledge of the Proposed Insured's habits, environment or other factors which might aid in the appraisal of the risk? \_\_\_\_\_  Yes  No  
(If 'Yes', explain in Remarks.)
23. Urine specimen forwarded to (Name of Laboratory) \_\_\_\_\_

\_\_\_\_\_ on (date) \_\_\_\_\_

24. Height in shoes \_\_\_\_\_ ft. \_\_\_\_\_ in.
25. Weight in clothes \_\_\_\_\_ lbs.
26. Girth - Chest at forced expiration \_\_\_\_\_ in.  
Chest at forced inspiration \_\_\_\_\_ in.  
Abdomen at umbilicus \_\_\_\_\_ in.
27. Blood Pressure:
- a. Systolic \_\_\_\_\_ mm.
- b. Diastolic \_\_\_\_\_ mm.
- c. Pulse rate \_\_\_\_\_
- d. Pulse irregularities \_\_\_\_\_

*Note: If blood pressure is 140/90 or higher, a recheck is required on another day. You may schedule for this now. Please note date of recheck.*

28. Is there a hernia?  
(If 'Yes', state where & reducible in Remarks)

## Remarks

29. Do you find any abnormality of:
- a. Sight or hearing \_\_\_\_\_  Yes  No
- b. Eyes, ears, nose, or throat \_\_\_\_\_  Yes  No
- c. Lungs or chest \_\_\_\_\_  Yes  No
- d. Abdominal organs or digestive tract \_\_\_\_\_  Yes  No
- e. Genito-urinary organs \_\_\_\_\_  Yes  No
- f. Nervous system including reflexes \_\_\_\_\_  Yes  No
- g. Thyroid, endocrine system, or skin \_\_\_\_\_  Yes  No
- h. Muscular or skeletal systems \_\_\_\_\_  Yes  No

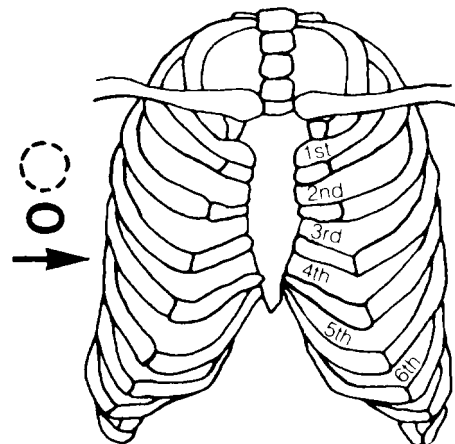
30. Heart - Do you find any:
- a. Enlargement \_\_\_\_\_  Yes  No
- b. Murmur(s) \_\_\_\_\_  Yes  No
- c. Dyspnea \_\_\_\_\_  Yes  No
- d. Edema \_\_\_\_\_  Yes  No

If murmur is present describe and illustrate

Systolic \_\_\_\_\_ Localized \_\_\_\_\_  
Diastolic \_\_\_\_\_ Soft I-II \_\_\_\_\_  
Presystolic \_\_\_\_\_ Moderate III-IV \_\_\_\_\_  
Constant \_\_\_\_\_ Loud V-VI \_\_\_\_\_  
Transmitted \_\_\_\_\_

Indicate:

- Apex by **X**
- Murmur area by **○**
- Heard loudest by **100**
- Transmission by **→**



- Effect of exercise  increase  decrease  none
- Effect of inspiration  increase  decrease  none
- Effect of expiration  increase  decrease  none
- Impression:

Name, Address & Telephone No. of Examining Facility  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location/Date & Time of Exam  
\_\_\_\_\_  
If exam not arranged by paramed company, Tax ID/EIN # required & please submit a separate "itemized" bill.

Signature of Physician/Paramedical \_\_\_\_\_