



Instructions:

- Be sure to use the current and correct state specific LSW 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. Are you a U.S. Citizen?
3. Height Weight lbs. Change in last year lbs. Reason?

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. Have you ever been diagnosed or treated for any physical disability or impairment?
b. Are you taking any prescription medications currently?
c. Have you ever applied for or received disability compensation from any source?
5. a. Within the past 10 years have you been advised by a physician or other medical professional to reduce alcohol intake or have you attended meetings of Alcoholics Anonymous?
b. Except as prescribed by a physician, have you ever used narcotic drugs, amphetamines, cocaine, barbiturates, tranquilizers, hallucinogens or marijuana?
c. Do you now use nicotine products in any form...
6. To the best of your knowledge, within the past 10 years, have you received professional treatment for:
7. To the best of your knowledge, within the past 10 years, have you received professional treatment or advice for disease or disorder of:
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:
9. Within the past 10 years have you tested positive for exposure to the Human Immunodeficiency Virus (HIV)...
10. Have you had x-rays, electrocardiograms or other diagnostic tests within the past 5 years?
11. Have you within the past 5 years been in or do you plan to enter or have you been advised by a person licensed in a medical profession...
12. Do you have pending, or do you intend to make within the next 30 days, an appointment with any physician or other medical professional?
13. Have you consulted any physicians or other medical professionals other than your personal physician within the past 5 years?
14. To the best of your knowledge, has any member of your family had diabetes, heart disease, cancer, Huntington's Disease or polycystic kidney disease?

Medical Questionnaire (Continued)

Instructions:

- Be sure to use the current and correct state specific LSW 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

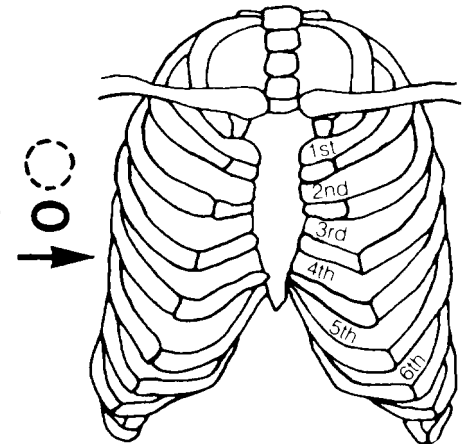
29. Do you find any abnormality of:
- a. Sight or hearing _____ Yes No
- b. Eyes, ears, nose, or throat _____ Yes No
- c. Lungs or chest _____ Yes No
- d. Abdominal organs or digestive tract _____ Yes No
- e. Genito-urinary organs _____ Yes No
- f. Nervous system including reflexes _____ Yes No
- g. 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 _____