

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.
- Paramedics 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 12 months? Yes No
6. To the best of your knowledge, within the past 10 years, have you been diagnosed or treated for:
- 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)

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_____ (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

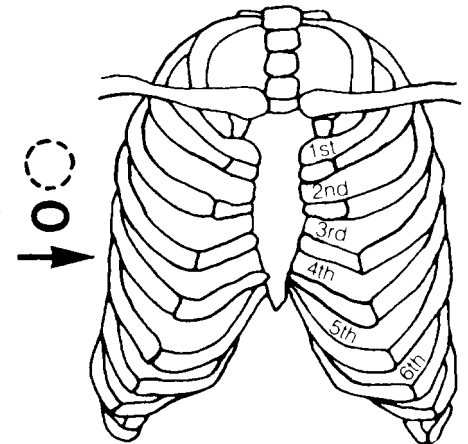
29. Do you find any abnormality of:
- a. Sight or hearing _____ Yes No
- b. Eyes, ears, nose, or throat _____ Yes No
- c. Lungs or chest _____ Yes No
- d. Abdominal organs or digestive tract _____ Yes No
- e. Genito-urinary organs _____ Yes No
- f. Nervous system including reflexes _____ Yes No
- g.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