LSW

Medical Questionnaire

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. Place of birth: ______________________

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. To the best of your knowledge, is your health impaired in any way? ☐ Yes ☐ No
   b. Are you taking any medications currently? If so, what and why? ☐ Yes ☐ No
   c. Have you ever applied for or received disability compensation from any source? ☐ Yes ☐ No
5. a. Within the past 10 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 or Alcoholics Anonymous? ☐ Yes ☐ No
   b. Except as prescribed by a physician, have you ever 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 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 treatment or 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. Within the past 10 years have you tested positive for the Human Immunodeficiency Virus (HIV), or has a physician or other medical professional diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related conditions? ☐ Yes ☐ No
10. Have you had x-rays, electrocardiograms or other diagnostic tests within the past 5 years? If so, where? ☐ Yes ☐ No
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, practicing within the scope of his or her license, to enter a hospital for observation, operation or treatment? ☐ Yes ☐ No
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? Why? ☐ Yes ☐ No
13. Have you consulted any physicians or other medical professionals other than your personal physician within the past 5 years? ☐ Yes ☐ No
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? ☐ Yes ☐ No

Medical Questionnaire *(Continued)*

15. Name and Address of Personal Physician *(if none, so state)* | Date last seen | Reason consulted & outcome

16. Family History

	Age if alive	State of Health	Age at death	Cause of death
Father				
Mother				
Siblings				
Siblings				

17. **Remarks** *(Provide dates, details, results & include physician's name, address and phone number to any questions so requested.)*

Question Number	Additional Information

I have read the answers to the foregoing questions. They are correctly recorded and they are complete and true to the best of my knowledge and belief. They shall be used by the Company in any action it takes.

(Please sign name in full)

Signature of Witness ______________________ Date ____________

Signature of Proposed Insured ______________________ Date ____________

Proposed Insured *(Print)* ______________________

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)

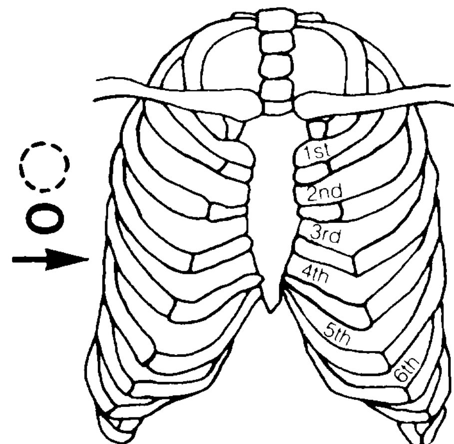
Remarks

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 O
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 ____________________