

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. 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 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 has a physician or other medical professional diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
10. Have you had x-rays, electrocardiograms or other diagnostic tests, not including tests for exposure to the Human Immunodeficiency Virus (HIV), within the past 5 years? If so, where? Yes No
11. Have you within the past 5 years had any test, hospitalization or surgery scheduled or completed based on the advice of a person licensed in a medical profession, practicing within the scope of his or her license? 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)*

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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

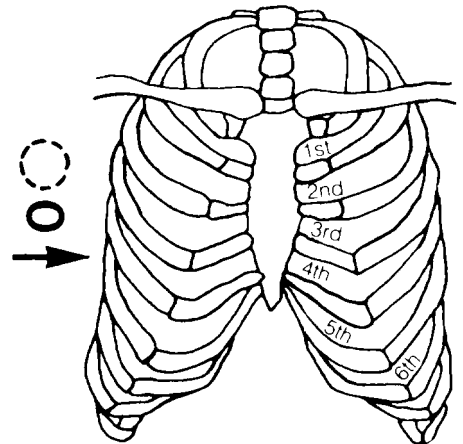
29. Do you find any abnormality of:
- a. Sight or hearing _____ Yes No
- b. Eyes, ears, nose, or throat _____ Yes No
- c. Lungs or chest _____ Yes No
- d. Abdominal organs or digestive tract _____ Yes No
- e. Genito-urinary organs _____ Yes No
- f. Nervous system including reflexes _____ Yes No
- g.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