

**REPORT OF MEDICAL EXAMINER**

- (1) Name of Applicant \_\_\_\_\_ Age \_\_\_\_\_
- (2) Does Applicant appear to be the age stated?  Yes  No
- (3) Is there any deformity, loss of member, or impairment of sight or hearing?  Yes  No
- (4) Pulse rate \_\_\_\_\_ Is pulse regular?  Yes  No
- (5) Blood pressure: Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_
- (6) Are heart sounds and rhythm normal?  Yes  No
- (7) Is a murmur present?  Yes  No  
Timing? \_\_\_\_\_ Transmission? \_\_\_\_\_  
Effect of exercise? \_\_\_\_\_ Degree? \_\_\_\_\_
- (8) Indication of hypertrophy?  Yes  No; Dilatation?  Yes  No
- (9) Heart diagnosis \_\_\_\_\_

(Comment if exercise causes undue dyspnea)

(10) Urine: Specific Gravity \_\_\_\_\_ Albumin? \_\_\_\_\_ Sugar? \_\_\_\_\_

(11) Do you find any abnormality in:

- A. Brain and nervous system?  Yes  No
- B. Thyroid or lymph glands?  Yes  No
- C. Chest, lungs and respiratory tract?  Yes  No
- D. Digestive system or abdominal organs?  Yes  No
- E. Genito-urinary system?  Yes  No
- F. Skin, bones, joints, spine?  Yes  No

(12) Is any factor not revealed above likely to affect longevity?  Yes  No

(13) How do you consider the insurance risk?  Good  Fair  Doubtful

(14) Please furnish details regarding all adverse information in items (2) through (13) above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, the Medical Examiner, certify that I made the above statements, that they are based on my own examination, and that the Applicant signed in my presence.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Medical Examiner

Medical Examiner's Name (please print) \_\_\_\_\_

Address (include zip) \_\_\_\_\_

Examination Fee \$ \_\_\_\_\_