MEDICAL EXAMINATION REPORT

Full name

Date of birth (dd/mm/yyyy)

Occupation

PART 1 CLIENT IDENTIFICATION

Have you satisfied yourself as to the identity of the client? Yes No

Please quote the applicant's identity card number/passport number:

Are you related to the client by birth or marriage or do you know the client in either a personal or professional capacity Yes No If Yes, please give details below.

IF THE APPLICANT IS UNABLE TO PROVIDE SATISFACTORY IDENTIFICATION, PLEASE DO NOT PROCEED.

PART 2 STATEMENT OF PERSONAL AND MEDICAL HISTORY – TO BE MADE BY THE EXAMINEE

Where necessary, questions should be enlarged upon by the examiner. If answering Yes to any of the questions, please give full details including dates and particulars.

1. Have you ever suffered from any of the following:

   a) Bronchitis, asthma, respiratory or lung condition? Yes No

   b) Anxiety, depression, nervous breakdown or any other nervous or mental disorder? Yes No

   c) Angina, heart attack, hypertension, rheumatic fever, heart murmur, circulatory disease or any other heart disorder? Yes No

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d) Stomach, bowel, liver or gall bladder disorder? ☐ Yes ☐ No

e) Disorders of the muscles, bones or joints, e.g. arthritis or gout? ☐ Yes ☐ No

f) Kidney, bladder or any other urinary disorder? ☐ Yes ☐ No

g) Cancers tumours, growths, moles, or enlarged glands of any kind? ☐ Yes ☐ No

h) CVA/stroke or neurological disorder? ☐ Yes ☐ No

i) Any disease of the ears, eyes or throat? ☐ Yes ☐ No

j) Any significant disease, physical abnormality, injury or scarring, not mentioned above? ☐ Yes ☐ No

k) Diabetes, sugar in the urine, thyroid glandular or blood disorder? ☐ Yes ☐ No

l) **Females only** – any disorder of the female organs (breasts ovaries, uterus) or abnormality of pregnancy or confinement, e.g. caesarean section or miscarriage? ☐ Yes ☐ No

2. a) Have you ever undergone any surgical operations, x-rays investigations or blood tests? ☐ Yes ☐ No

b) Are you receiving any form of medical treatment including prescribed medicine or drugs? ☐ Yes ☐ No

3. Have you ever been tested, received medical advice, counselling or treatment in connection with AIDS or HIV or any other sexually transmitted disease including Hepatitis B? ☐ Yes ☐ No

4. Have you ever taken drugs other than for medical purposes? ☐ Yes ☐ No

5. a) How much alcohol do you consume weekly and in what form? Please note that “N/A”, “-“ and “/” are not acceptable answers.

Beer (litres) ☐ Wine (125ml glasses) ☐ Spirits (measures) ☐

b) How much tobacco do you use daily and in what form?

Cigarettes ☐ Cigars ☐ Gms of tobacco ☐

If you are an ex-smoker, please confirm when you stopped and what your previous usage was.

Do you use nicotine replacement such as e-cigarettes or patches? ☐ Yes ☐ No

c) Has either your smoking or alcohol usage differed significantly in the past? ☐ Yes ☐ No

d) Has any insurer ever declined, postponed or accepted an application on your life on special terms, or have you withdrawn an application? ☐ Yes ☐ No

6. Does/has any member of your immediate family:

a) Suffer/ed from cancer, diabetes, stroke, kidney disease, multiple sclerosis, heart disease, high blood pressure? ☐ Yes ☐ No

b) Suffer/ed from any hereditary disease? ☐ Yes ☐ No

c) Died before the age of 65? ☐ Yes ☐ No

Please complete the following section.

Family member	If living		If dead	
	Age	State of health	Age at death	Cause of death
Father				
Mother				
Brother(s)				
Sister(s)				

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Our full privacy policy can be viewed at www.rl360.com/privacy or can be obtained by requesting a copy from our Data Protection Officer.

DECLARATION

To be signed by the person who is being examined.

I declare that the above answers are true to the best of my knowledge and that I have not withheld any information that may influence the assessment or acceptance of this application.

I give my express consent for the information in this form to be processed.

I agree that any supplementary questionnaire will form part of my application to the company and that non-disclosure of any material fact known to me may invalidate the contract.

Signature of examinee

Date (dd/mm/yyyy)

PART 3 MEDICAL EXAMINATION

Answers to be given by the doctor. Please give full details where appropriate.

Measurements (stripped to underclothing)

Height: ☐ Feet ☐ Inches ☐ Centimetres

Weight: ☐ Pounds ☐ Kilograms

Chest: Inspiration ☐ Inches ☐ cm Expiration ☐ Inches ☐ cm Abdomen ☐ Inches ☐ cm

1. General

a) To your knowledge is the weight (please tick as appropriate) ☐ Stationary ☐ Increasing ☐ Diminishing

Please provide additional information where appropriate

b) Describe the general appearance and build

c) Does the appearance correspond with the stated age? ☐ Yes ☐ No If No, please give full details.

d) Are there any signs of physical abnormalities or previous operations or trauma (e.g. scarring)? ☐ Yes ☐ No If Yes, please give full details.

e) Is there any evidence of excessive habits? ☐ Yes ☐ No If Yes, please give full details.

2. Lungs

a) Is the chest well developed and does it expand freely? ☐ Yes ☐ No If No, please give full details.

b) Are there any abnormal physical signs? ☐ Yes ☐ No If Yes, please give full details.

c) Are the breath sounds normal? ☐ Yes ☐ No If No, please give full details.

3. Heart

a) Is the position of the apex beat normal? ☐ Yes ☐ No If No, please give full details.

b) Is it unduly forceful?

☐ Yes ☐ No If Yes, please give full details including dates and particulars.

c) Is the heart enlarged?

☐ Yes ☐ No If Yes, please give full details.

d) Is there any abnormality of the heart sounds or any murmurs present?

☐ Yes ☐ No If Yes, please describe the murmur and state whether considered functional or organic in origin and give reasons

e) Is the heart rhythm normal?

☐ Yes ☐ No If No, please give full details.

4. Pulse

a) Measure the rate and describe the character.

b) What is the state of the arterial walls?

c) Is there any vascular abnormality in the legs or reduced foot pulses?

☐ Yes ☐ No If Yes, please give full details.

5. Blood pressure

If the first reading exceeds 140 systolic or 90 diastolic (5th phase), please take 2nd and 3rd readings at 5 minute intervals.

	1st reading	2nd reading	3rd reading
Systolic			
Diastolic (5th phase)			
Pulse			

6. Nervous system

a) Are the pupil reactions normal?

☐ Yes ☐ No If No, please give full details.

b) Are the knee and ankle reflexes and gait normal?

☐ Yes ☐ No If No, please give full details.

c) Are speech, memory and sight normal?

☐ Yes ☐ No If No, please give full details.

d) Is there evidence of an ear disorder or is the hearing impaired?

☐ Yes ☐ No If Yes, please give full details.

e) Is there evidence of any disease of the central nervous system?

☐ Yes ☐ No If Yes, please give full details.

7. Abdomen

a) Is there any evidence of past or present digestive trouble, or disorder of:

i) the liver?

☐ Yes ☐ No If Yes, please give full details.

ii) the spleen?

☐ Yes ☐ No If Yes, please give full details.

iii) the stomach?

☐ Yes ☐ No If Yes, please give full details.

iv) the bowels?

☐ Yes ☐ No If Yes, please give full details.

b) Is there a hernia present?

☐ Yes ☐ No If Yes, please give full details.

8. Urine

If any abnormality is discovered and the life proposed presents no other evidence of renal disease, it would be helpful if he/she is asked to call again and bring two specimens of his/her urine – one passed at night on retiring and the other passed on rising in the morning. The result of the test in each case should be recorded separately.

a) Is albumin present? ☐ Yes ☐ No

b) Is sugar present? ☐ Yes ☐ No

c) Is blood present? ☐ Yes ☐ No

d) Any other abnormalities? ☐ Yes ☐ No

9. Additional information

Please elaborate on any relevant answers given by the examinee and/or any abnormal findings which are significant. Please attach additional sheets if necessary.

RL360's medical examiners reference number

Medical Attendant's full name (please print)

Qualifications

Address

Telephone number

Email address

Signature

Date of birth (dd/mm/yyyy)

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