



AMERICAN PARA PROFESSIONAL SYSTEMS, INC.

Examined for \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy \_\_\_\_\_

Name of Agent \_\_\_\_\_ No: \_\_\_\_\_

Type of Insurance: Life  Health  Other

Proposed Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_

First Name \_\_\_\_\_ M. I. \_\_\_\_\_ Last Name \_\_\_\_\_ Month/Day/Year \_\_\_\_\_

1. a. Name and address of your personal physician (*If none, so state*) \_\_\_\_\_
- b. Date and reason last consulted? \_\_\_\_\_
- c. What treatment was given or medication prescribed? \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 2. Have you ever been treated for or ever had any known indication of:  |                          |                          |
| a. Disorder of eyes, ears, nose, or throat?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes; thyroid or other endocrine disorders?  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Deformity, lameness or amputation?   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of the skin or lymph glands, unexplained fevers, AIDS or immune deficiency disease, cyst, tumor or cancer?  | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies, anemia or other disorder of the blood?  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Excessive use of alcohol, tobacco, or any habit forming drugs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now under observation or taking treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any change in weight in the past year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. <i>Other than above</i> , have you within the past 5 years:  |                          |                          |
| a. Had any mental or physical disorder not listed above?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had a checkup, consultation, illness, injury, surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had electrocardiogram, X-ray, other diagnostic test?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?   | <input type="checkbox"/> | <input type="checkbox"/> |

DETAILS of "YES" answers. (IDENTIFY QUESTION NUMBER. CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

	Age if living	Cause of Death?	Age at Death?	9. Females only	Yes	No
Father				a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts?	<input type="checkbox"/>	<input type="checkbox"/>
Mother				b. To the best of your knowledge and belief are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Brothers and Sisters						
No. Living _____						
No. Dead _____						

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

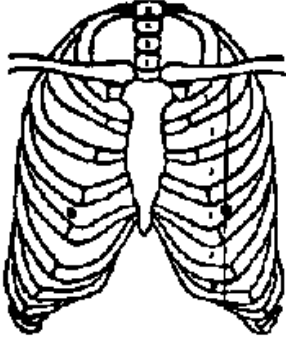
Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Witness \_\_\_\_\_

(Signature of Examiner)

(Signature of Proposed Insured)

Rev. 12/99

10a. Height (In Shoes) ____ ft. ____ in.		Weight (Clothed) _____ lbs.		MALES ONLY:			Details of "Yes" answers. (Identify item.)																																																																														
				Chest (Full Inspiration) _____ in.	Chest (Forced Expiration) _____ in.	Abdomen, at Umbilicus _____ in.																																																																															
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No    Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																					
11. Blood Pressure (Record ALL readings) <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Systolic</td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> <tr> <td rowspan="2">Diastolic</td> <td style="border: 1px solid black; padding: 2px;">4<sup>th</sup> phase</td> <td></td> <td></td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">5<sup>th</sup> phase</td> <td></td> <td></td> </tr> </table>							Systolic				Diastolic	4 <sup>th</sup> phase			5 <sup>th</sup> phase																																																																						
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12. Pulse: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"></td> <td style="width: 20%;">At Rest</td> <td style="width: 20%;">After Exercise</td> <td style="width: 20%;">3 Minutes Later</td> </tr> <tr> <td>Rate</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Irregularities per min.</td> <td></td> <td></td> <td></td> </tr> </table>								At Rest	After Exercise	3 Minutes Later	Rate				Irregularities per min.																																																																						
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13. Heart: Is there any <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Enlargement</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> <td style="width: 10%;"><input type="checkbox"/> No</td> <td style="width: 30%;">Dyspnea</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> <td style="width: 10%;"><input type="checkbox"/> No</td> </tr> <tr> <td>Murmur(s)</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Edema</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table> <p>(describe below – if more than one, describe separately)</p> <p>Location <span style="border: 1px solid black; display: inline-block; width: 40px; height: 20px; vertical-align: middle;"></span> <span style="border: 1px solid black; display: inline-block; width: 40px; height: 20px; vertical-align: middle;"></span></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Constant</td> <td style="width: 5%;"><input type="checkbox"/></td> <td style="width: 5%;"><input type="checkbox"/></td> <td rowspan="4" style="width: 10%; vertical-align: middle;">Indicate:</td> <td rowspan="4" style="width: 10%;"></td> </tr> <tr> <td>Inconstant</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Transmitted</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Localized</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Systolic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td style="vertical-align: middle;">Apex by</td> <td rowspan="4" style="width: 10%;"></td> </tr> <tr> <td>Presystolic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td style="vertical-align: middle;">Murmur area by</td> </tr> <tr> <td>Diastolic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td style="vertical-align: middle;">Point of greatest intensity by</td> </tr> <tr> <td>Soft (Gr. 1-2)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td style="vertical-align: middle;">Transmission by</td> </tr> <tr> <td>Mod. (Gr. 3-4)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Loud (Gr. 5-6)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td colspan="2">After Exercise:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Increased</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Absent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Unchanged</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Decreased</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table> <div style="text-align: center; margin-top: 10px;">  <p>For comments and your impression:</p> </div>							Enlargement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dyspnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Murmur(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Edema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Constant	<input type="checkbox"/>	<input type="checkbox"/>	Indicate:		Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Localized	<input type="checkbox"/>	<input type="checkbox"/>	Systolic	<input type="checkbox"/>	<input type="checkbox"/>	Apex by		Presystolic	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	Diastolic	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>			Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>			After Exercise:					Increased	<input type="checkbox"/>	<input type="checkbox"/>			Absent	<input type="checkbox"/>	<input type="checkbox"/>			Unchanged	<input type="checkbox"/>	<input type="checkbox"/>			Decreased	<input type="checkbox"/>	<input type="checkbox"/>			
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14. Is there on examination any abnormality of the following: <i>(Circle applicable items and give details.)</i> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> </tr> <tr> <td>(a) Eyes, ears, nose, mouth, pharynx?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? <i>(If vision or hearing markedly impaired, indicate degree and correction.)</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(c) Nervous system (include reflexes, gait, paralysis)?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(d) Respiratory system?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(e) Abdomen (include scars)?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(f) Genitourinary system (include prostate)?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(g) Endocrine system (include thyroid and breasts)?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(h) Musculoskeletal system (include spine, joints, amputations, deformities)?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>								Yes	No	(a) Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>	(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? <i>(If vision or hearing markedly impaired, indicate degree and correction.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	(c) Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>	(d) Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	(e) Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>	(f) Genitourinary system (include prostate)?	<input type="checkbox"/>	<input type="checkbox"/>	(g) Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>	(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>																																																				
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15. (a) Are there any hernias? <input type="checkbox"/> Yes <input type="checkbox"/> No    Any hemorrhoids? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																					
16. Does proposed insured smoke? If yes, give details <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																					
17. Are you aware of additional medical history? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																					
Urinalysis: Specific Gravity	Albumin	Sugar	Are you related by blood or marriage to proposed insured?																																																																																		
			<input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																		
Is specimen being sent to lab <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																					

I certify that I have carefully examined \_\_\_\_\_ of \_\_\_\_\_ (Address)  
 in private at  my office  his place of business  his home this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_ A.M./P.M.  
 Signature of Examiner \_\_\_\_\_ Address \_\_\_\_\_