SUTTON
SPECIAL RISK

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MEDICAL EXAMINER'S REPORT - CONFIDENTIAL

ALL PARTS TO BE COMPLETED BY THE MEDICAL EXAMINER

PART 1: PERSONAL DETAILS

Please ask the person to be insured the following:

Surname: _____ Given name(s): _____ Mr. / Mrs. / Ms. / Miss

Marital Status: (married, single, divorced, separated, widowed, common-law): _____ Sex: male / female

Date of Birth: _____ Occupation: _____
(day/month/year)

Address: _____
No. Street City Province Postal Code

PART 2: MEDICAL HISTORY

Please ask the person to be insured the following questions and qualify if necessary:

1a) Are you in good health? ..... **Yes/No**
b) Do you usually enjoy good health? ..... **Yes/No**

If you responded **No** to question 1a or 1b, please provide **full details**, **dates**, and **name** and **address** of Medical Practitioner consulted:_____

_____

2) **Have you <u>at any time</u> had investigations for, suffered from or had symptoms of:**

a) Blackouts, depression, anxiety state, mental disorder or nervous disease? ..... **Yes/No**
b) Tuberculosis, pleurisy, asthma, pneumonia, bronchitis, persistent cough or spitting of blood? ..... **Yes/No**
c) Palpitation, fainting, undue shortness of breath, raised blood pressure or any heart trouble? ..... **Yes/No**
d) Chronic indigestion, gastric or duodenal ulcer or any other disorder of the stomach, liver or bowels?..... **Yes/No**
e) Diabetes or any disorder of the kidneys, bladder or urinary system? ..... **Yes/No**
f) Any form of sexually transmitted disease including Hepatitis B, C and AIDS? ..... **Yes/No**
g) Rheumatism, arthritis, gout, rheumatic fever, back trouble, lumbago or sciatica? ..... **Yes/No**
h) Enlarged glands or tumours, cysts or swellings? ..... **Yes/No**
i) Any disease, injury or disability not mentioned above? ..... **Yes/No**

For each <u>Yes</u> answer under question 2, please give <u>full details</u> (name, dates and address of Medical Practitioner consulted, diagnosis, prognosis, treatments, dosage etc). If you require more space, please attach a separate sheet of paper. Please ensure you date and sign any additional pages and attach them to this form.

Question #	Date	Details

3) Have you had or are you contemplating any other medical investigations, blood tests, chest x-rays or check-ups? ……..…..…..... **Yes/No**

4)Are you taking any medicine or drug at the present time (whether prescribed or not)? ……..……..…….. **Yes/No**

5) Have you ever taken drugs other than for medical purposes? ……..…..……..…..…… **Yes/No**

6) Have you undergone or are you in prospect of undergoing any operation? …….. **Yes/No**

If you responded Yes to question 3, 4, 5, or 6, please provide full details and dates:

Question #	Date	Details

7) How many days have you lost from work in the last year through illness or injury? _____

8a) How much to do smoke **per day**? Cigarettes _____ Cigars_____ Pipe _____

b) How much to do smoke **per week**? Cigarettes _____ Cigars_____ Pipe _____

c) If you have given up smoking, when did you stop? _____

d) Was this on medical advice? **Yes/No** If **yes**, please state **why**: _____

9a) Indicate your average weekly consumption of units of alcohol:
Note: 1 unit is equivalent for ½ pint of beer or lager, 1 glass of wine or 1 ounce of spirits

Beer _____ Wine _____ Liquor _____

b) If abstained, how long have you been so? _____

c) Have you been advised by a medical practitioner to reduce your consumption of alcohol? **Yes/No** If **yes**, please provide **full details**:_____

_____

10) Have any of your near relatives, whether living or dead, suffered from epilepsy, diabetes, mental disorder, cancer, stroke or disease? **Yes/No** If **yes**, please provide **full details** and **dates**: _____

_____

11) Family history:	**If Living**		**If Dead**	
	Present age	State of health	Age at death	Cause of death
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				

I consent to Sutton Special Risk making known, in my best interests, to my doctor (whose name and address I have provided) any medical information that is elicited by independent medical examination that may be relevant to my care of which he or she may be unaware**. I declare that the particulars given are true and that I have not withheld any material information.**

Signature of proposed Insured: _____ Date: _____
(day/ month/year)

Signature of the Medical Examiner: _____ Date: _____
(day/ month/year)

PART 3: EXAMINATION

You are particularly requested not to give details of your report to the person to be insured.

Please report on the following:

1) Have you any personal or professional knowledge of the proposed Insured? **Yes/No** If **yes**, please provide **full details**:

_____

_____

2) Does he/she look older than the stated age? **Yes/No** If **yes**, please provide **full details**:

_____

_____

3) Describe their general appearance and build:_____

_____

4) Height: With/ Without shoes?_____ feet and inches **or** _____ cms

Chest girth: On inspiration? _____ ins/cms On expiration?_____ ins/cms

Weight (actual): _____ pounds/kgs

Has the weight increaseded ☐ or decreased ☐ in the past year?

Abdominal girth: _____ ins/cms

5) Please examine the proposed Insured and report on the following. Do you detect abnormality in:

a) Mouth, Pharynx, Ears (including hearing) ..... Yes/No
b) Cardiovascular system (if any abnormality, give result of exercise tolerance test.) Record blood readings in question 7 below ..... Yes/No
c) Respiratory system ..... Yes/No
d) Nervous system (including eyes and visual acuity) ..... Yes/No
e) Abdomen ..... Yes/No
f) Hernial orifices ..... Yes/No
g) Musculo skeletal (please evaluate spinal movements) ..... Yes/No
h) Genito-Urinary System ..... Yes/No

6) Urinalysis:

a) Is albumen present? **Yes/No** If **yes**, please state **amount**: _____
b) Is sugar present? **Yes/No** If **yes**, please state **amount**: _____
c) Is blood present? **Yes/No** If **yes**, please state **amount**: _____

7) Blood Pressure:

	First reading	Subsequent readings *	Further readings on another day †
Systolic			
Diastolic (4th phase)			
Diastolic (5th phase)			

Pulse rate _____ Date _____
(day/ month/year)

*Required if the first reading is over 140 (systolic) or 95 (4th phase) 90 (5th phase), or if pulse rate is abnormal.

† Required if the blood pressure readings on the first day are persistently outside the limits referred to above.

8) Female applicants only:

a) Has there been any apparent abnormality in the uterine functions? **Yes/No** If **yes**, please provide **details**:

_____

b) Has she borne children? **Yes/No** If **yes**, state how many: _____

c) Has her health been affected? **Yes/No** If **yes**, please provide **details**: _____

d) Is she pregnant now? **Yes/No**

9) Male applicants only:

Do you find anything to suggest that the applicant may be at risk of infection by the Human Immunodeficiency Virus or any other sexually transmitted diseases? **Yes/No** If **yes**, please provide **details:**

_____

_____

10) General remarks:

Please use this space to amplify the information given in the main body of the report, particularly if abnormality has been found.

_____

_____

_____

11) Do you think the proposed Insured, on careful examination and on consideration of the medical record and history disclosed to you is an average risk for:

a) Life insurance?_____

b) Group Income Protection Cover terminating at age 65? (non- cancellable disability coverage in case of sickness, accident or operation)_____

_____

Signature: _____ **Date:** _____
(day/month/year)

Qualifications: _____ **Date:** _____
(day/month/year)