

Medical Examination (Confidential)



Report on physical examination of the applicant.

1 Personal details

Full name

Address

Date of birth

Day	Month	Year
/	/	

2 General

- (a) Do you know the applicant? ☐ Yes ☐ No
- (b) Have you ever attended the applicant? ☐ Yes ☐ No
- (c) Is the applicant's build, appearance or behaviour unusual? (eg. skin rashes, pigmentation) ☐ Yes ☐ No
- (d) Are there any signs of past or present over indulgence in tobacco or alcohol or the misuse of drugs? ☐ Yes ☐ No

3 Measurements (taken by doctor)

Height

Chest – Full inspiration

Weight

Full expiration

Abdomen at umbilicus

Has there been any recent variation in weight?

☐ Yes ☐ No

If Yes, please try to ascertain the cause

4 Respiratory system

- (a) Is there any abnormality in the shape or expansion of the chest? ☐ Yes ☐ No
- (b) Is there any abnormality in the percussion note or breath sounds? ☐ Yes ☐ No
- (c) Are there any other signs of past or present disease? ☐ Yes ☐ No

5 Cardio-Vascular system

If YES, please describe as fully as possible, including the effect of exercise and posture, where applicable

- (a) Is the pulse abnormal in the rhythm or character? ☐ Yes ☐ No
- (b) Is the apex beat abnormal in site or character? ☐ Yes ☐ No
- (c) Is the heart enlarged or hypertrophied? ☐ Yes ☐ No

Cardio-Vascular system (continued)

If Yes, please describe as fully as possible, including the effect of exercise and posture, where applicable

- (d) Are there any abnormal heart sounds or murmurs?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

- (e) Are there any signs of disease in the veins or arteries of the legs? (eg. varicosity, oedema)

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

- (f) Blood pressure. Please record the diastolic pressure at the cessation of all sound. If the first reading exceeds 135/85 please take two further readings after the applicant has been resting for 5 and 10 minutes.

Systolic	Diastolic	Pulse rate

6 Digestive system

- (a) Is there any palpable abnormality of the liver, spleen or other abdominal organs?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes, please give details

- (b) Is a hernia present?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes, please state whether it is likely to require surgical repair

7 Genito-Urinary system

- (a) Is there any genito-urinary abnormality? (eg. stricture, prostate)

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes, please give details

- (b) Does the urine contain:

Albumin	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Sugar	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Other abnormality	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

The urine should be passed in the presence of the doctor. If not, please state circumstances.

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FEMALE APPLICANTS ONLY

- (c) Is the applicant pregnant? If Yes, please state expected date of delivery and provide details of any complications.

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Expected date of delivery	Day	Month	Year

- (d) Is there any abnormality in the uterine functions or in the obstetric history?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes, please give details

8 Nervous system and special senses

- (a) Are the pupils unequal or do they react abnormally?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes, please give details

Nervous system and special senses (continued)

- (b) Is there any disease of the eyes or abnormality of the fundi? ☐ Yes ☐ No
- (c) Are the tendon reflexes or plantar responses abnormal? ☐ Yes ☐ No
- (d) Is there any defect in the ears, hearing or speech? ☐ Yes ☐ No
- (e) Is there any other sign of disease of the nervous system? ☐ Yes ☐ No
- (f) Is there any evidence of disability of the joints? Please pay particular attention to the form and movement of the back. ☐ Yes ☐ No

9 Summary and comments

PLEASE INDICATE IF YOU CONSIDERED IT NECESSARY TO ADVISE THE APPLICANT OF ANY OF YOUR FINDINGS

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- (a) Do you consider the application to be predisposed to any particular medical condition or likely to require surgery in the future? ☐ Yes ☐ No
- (b) Please comment fully on any unfavourable features in the personal or family medical history or disclosed by your medical examination.
- (c) Do you consider any reports or special tests are required? ☐ Yes ☐ No
- (d) Do you consider the applicant has normal prospects of longevity and good health for employment purposes? ☐ Yes ☐ No
- Name (in block letters)
- By whom was the applicant referred to you?
- Address
- Professional qualifications

10 Declaration

I, the applicant, hereby authorise the release of the information contained within this report to AIA New Zealand Limited, or any related companies. I also authorise AIA New Zealand Limited or any related company to disclose the information contained within this report to such persons or organisations necessary for the purposes of assessing, reinsuring, or enforcing my application for risk benefits.

Signature of applicant

Date

Signature of doctor

Date

The completed report should be sent to:

THE CHIEF UNDERWRITER, AIA Services New Zealand Limited
Private Bag 92499, Victoria Street West, Auckland 1142

Additional notes