

MEDICAL EXAMINATION FORM

Client name:

Date of Birth:

D M Y

Reference Number:

Section A – Medical Questionnaire

SECTION A – Answers by the Life proposed to questions put to him/her by the Medical Examiner.

We would appreciate details regarding dates of diagnosis, treatment, name and address of specialists that may have been attended and whether a full recovery has been made.

1. Are you now in all aspects of good health?

Yes ☐
No ☐

If NO please provide full details

2. Have you ever suffered from or had investigations or required medical attention for the following:

If YES please provide full details

(a) Anxiety, depression, eating disorder, nervous breakdown, psychiatric disorder, stress or insomnia?

Yes ☐
No ☐

(b) Asthma, bronchitis, pleurisy, pneumonia, tuberculosis, sarcoidosis, persistent cough or any disease of the lungs?

Yes ☐
No ☐

(c) Fainting, epilepsy, blackouts, any tremor, dizziness, numbness, pins and needles, or visual disturbance not corrected by lenses?

Yes ☐
No ☐

(d) Multiple sclerosis, any form of paralysis, or any disease or disorder of the nervous system?

Yes ☐
No ☐

(e) Stroke, high blood pressure, chest pain, palpitations, breathlessness, high cholesterol, heart attack, angina or any disease or disorder of the heart or circulatory system?

Yes ☐
No ☐

(f) Diabetes or any disorder of the kidneys, bladder, urinary or reproductive system?

Yes ☐
No ☐

(g) Recurrent indigestion, gastric or duodenal ulcer, irritable bowel syndrome, colitis, Crohn's disease or any disease or disorder of the stomach, bowel, liver, pancreas or spleen?

Yes ☐
No ☐

(h) Rheumatoid arthritis, Osteoarthritis, rheumatic fever, gout, disc problems, whiplash, sciatica, or any disorder of the back, neck or joints?

Yes ☐
No ☐

(i) Any form of cancer, tumour, lump, cyst, mole, swollen glands or growth?

Yes ☐
No ☐

If YES, confirm date, site and whether benign or malignant

(j) Any disorder of the skin, eyes, ears or any defect of hearing or sight?

Yes ☐
No ☐

3. Have you:

If YES please provide full details

(a) Had any disease, injury or disability not mentioned above?

Yes ☐
No ☐

(b) Had or are you contemplating any other medical investigations, blood tests or check-ups?

Yes ☐
No ☐

4. Are you taking any medicine or drug at present (whether prescribed or not)?

Yes ☐ If YES, please provide the name of the drug and reason
No ☐

5. Have you:

If YES please provide full details

(a) Ever taken drugs for other than medical purposes?

Yes ☐
No ☐

(b) Ever had in-patient treatment for alcohol or drug abuse or been given medical advice to reduce or stop your alcohol intake?

Yes ☐
No ☐

6. Have you ever tested positive for HIV, hepatitis B or hepatitis C or are you awaiting the results of such a test?

Yes ☐ If YES please provide full details
No ☐

7. Have you had at any time in the past or are you on a waiting list for: a surgical operation, X-Ray, ECG, blood test, investigation or treatment at a hospital, clinic or nursing home?

Yes ☐ If YES please provide full details
No ☐

8. Do you drink alcohol?

Yes ☐ No ☐

If YES, please advise:

(a) How many units of alcohol per week?

Units

(b) Has this level changed in the past 10 years?

Yes ☐ If YES please provide full details
No ☐

9. Do you Smoke?

Yes ☐ No ☐

If YES, please advise:

(a) How many cigarettes do you smoke per day?

Cigarettes/Cigars/Tobacco per day
(please circle one type)

(b) If non smoker now, please advise whether you smoked in the past?

Yes ☐ No ☐

If YES, please advise, how many cigarettes you smoked per day and when you stopped smoking?

Cigarettes/Cigars/Tobacco per day
(please circle one type)

Stopped D M Y

10. Is there any family history of kidney disease, diabetes, stroke, hypertension, heart disease, cancer, multiple sclerosis or hereditary/familial disorder (such as Huntington's chorea, Polycystic Kidney Disease)? (If cancer, please state location and type and age at diagnosis)

Yes ☐ No ☐

Relative	Age	If Living, please advise state of health	Age at Diagnosis	If Deceased, please advise cause of death and age
Mother				
Father				
Sister				
Brother				
Partner				

I declare that to the best of my knowledge all the answers and statements in this questionnaire, whether completed by me or written down on my behalf at my dictation, are true and complete in every particular, and shall form part of the basis of my application for insurance. I understand that I must disclose all material facts. A material fact is any fact about your health, smoking or drinking habits, occupation, pastimes, policies with other insurance companies or any other fact that may influence the assessment and acceptance of your application by Royal London. If you are in any doubt about whether certain facts are material, these facts should be disclosed.

I understand that I must advise Royal London immediately, in writing, of any material facts or changes to any of the information given to Royal London which occur between the date I sign this declaration and the date that cover commences.

I understand that failure to disclose all material facts or provide Royal London with full and accurate information may result in any subsequent claim being rejected and the policy being cancelled from inception.

Signature of the Client:

Date D M Y

Witness Signature:

Date D M Y

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Section B – Examination of the client

11. Is this client a patient of your surgery?

Yes ☐
No ☐

If YES please advise for how long

12. Does he/she look older than the stated age?

Yes ☐ No ☐

13. Please describe the general appearance and build.

14. Is there any apparent abnormality?

Yes ☐
No ☐

If YES please provide full details

15. Height feet in cm

16. Weight st lb kg

19. Has the weight changed in the last year?

Yes ☐
No ☐

If YES why?

20. Abdominal Girth

in/cm

21. Is there any abnormality of the following?

(a) Cardio-vascular system

Yes ☐
No ☐

If any known abnormality, please give date and result of all investigations

i. Are the heart sounds and rhythm normal?

Yes ☐ No ☐

ii. Please advise the position of the apex beat.

iii. Please describe all murmurs. If murmur is audible please advise whether systolic/diastolic, appears functional (innocent or not and grade intensity i.e. (1–4/6)

Blood Pressure	First Reading	Subsequent Reading (required if the 1st reading is over 140/90, 5th phase)	Further Reading on another day (required if the BP readings are persistently raised)
Systolic			
Diastolic (to be at fifth phase i.e. cessation of sound)			
Pulse Rate/Rhythm (if over 90 please recount at the end of the examination)			

(b) Respiratory System

Are the lungs normal to percussion and auscultation?

Yes ☐
No ☐

If there is evidence of past or present disease please record Peak Flow Rate

(c) Nervous System

i. What is the condition of the ears?

Please comment on hearing in both ears

ii. What is the condition of the eyes?

Please comment on vision in both eyes

iii. Are there any abnormalities of the reflexes, the motor or sensory systems?

Yes ☐
No ☐

If YES please provide full details

iv. Are there any abnormalities of co-ordination?

Yes ☐
No ☐

If YES please provide full details

(d) Digestive organs

- i. Is there any abnormality of the teeth, gums, tongue or throat?
- ii. Is there any abnormality of the abdomen apparent on palpation?
- iii. Is there any evidence of hernia?

Yes	<input type="checkbox"/>	If YES please provide full details
No	<input type="checkbox"/>	
Yes	<input type="checkbox"/>	If YES please provide full details
No	<input type="checkbox"/>	
Yes	<input type="checkbox"/>	If YES please provide full details
No	<input type="checkbox"/>	

(e) Musculo skeletal

Is there any muscular or bony abnormality, or impairment of spinal or joint function?

Yes	<input type="checkbox"/>	If YES please provide full details
No	<input type="checkbox"/>	

(f) Genito-urinary System

Is there any abnormality of the reproductive organs?

Yes	<input type="checkbox"/>	If YES please provide full details
No	<input type="checkbox"/>	

22. Urine

The sample should be passed at the time of the examination. If protein/blood/glucose are found – please repeat urinalysis on an early morning sample (fasting where glycosuria) – if the abnormality persists please send sample to the laboratory for microscopic urinalysis/C&S. Repeat samples are not required for those menstruating where blood is found in the urine.

- (a) Is albumen present?
- (b) Is sugar present?
- (c) Is blood present?
- (d) Is there any other abnormality?

Yes	<input type="checkbox"/>	If YES please provide full details
No	<input type="checkbox"/>	
Yes	<input type="checkbox"/>	
No	<input type="checkbox"/>	
Yes	<input type="checkbox"/>	
No	<input type="checkbox"/>	
Yes	<input type="checkbox"/>	
No	<input type="checkbox"/>	

23. Female Lives

- (a) Any history of an abnormal smear test/ mammogram or breast ultrasound?
- (b) Has she borne children?
- (c) Is there history of complications related to pregnancy?
- (d) Is she currently pregnant?

Yes	<input type="checkbox"/>	If YES please provide full details
No	<input type="checkbox"/>	
Yes	<input type="checkbox"/>	
No	<input type="checkbox"/>	
Yes	<input type="checkbox"/>	
No	<input type="checkbox"/>	
Yes	<input type="checkbox"/>	
No	<input type="checkbox"/>	

24. Additional Observations

Is there anything else you would like to bring to the Company's notice, or have you suggested anything to the client that should be followed up on or warrants further investigation?

25. Opinion

Following your examination and on consideration of the medical facts that have been disclosed to you by the client, do you think that the Client is an average risk for:

a. Life Insurance? ☐

b. Serious Illness? ☐

Signed:

Qualifications:

Date: D M Y

Name and Address

(in capitals please, required for payment)

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