ROYAL LONDON

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. 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

2. 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 with a GP or specialist? Yes No

3. Are you taking any medicine or drug at present (whether prescribed or not)? Yes No — If YES, please provide the name of the drug and reason

Medical Examination Form

4. 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 ☐

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

Yes ☐ No ☐ If YES please provide full details

6. 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 ☐ No ☐ If YES please provide full details

7. 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 ☐ No ☐ If YES please provide full details

8. Do you smoke or use e-cigarettes or any other nicotine replacement products?

Yes ☐ No ☐

If YES, please advise:

(a) What is your daily consumption?

Cigarettes/Cigars/Tobacco/ Nicotine Replacement Product *(please circle one type)*

(b) If non smoker now, please advise whether you smoked or used e-cigarettes or any other nicotine replacement products in the past?

Yes ☐ No ☐

If YES, please advise your previous daily consumption and when you stopped smoking/using e-cigarettes or a nicotine replacement product.

Cigarettes/Cigars/Tobacco/Nicotine Replacement Product *(please circle one type)*

Stopped D ☐☐ M ☐☐ Y ☐☐☐☐

9. Is there any family history of kidney disease, diabetes, stroke, hypertension, heart disease, cancer, multiple sclerosis or hereditary/familial disorder (such as Huntington's Disease, 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
Father				
Mother				
Sisters				
Brothers				

We understand this information is very personal. It will only be used to underwrite your application, in the event of a claim or if your case is selected for review – internal, by our Reassurers or Medical experts. For more information see our privacy notice at royallondon.ie/legal-cookies-/privacy

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

10. Is this client a patient of your surgery?
If the client is not a patient, please delete all medical data on completion of the examination.

Yes ☐ No ☐ — If YES please advise for how long

11. Please describe the general appearance and build.

12. Is there any apparent abnormality?

Yes ☐ No ☐ — If YES please provide full details

13. Height — ☐ feet ☐ in ☐ cm

14. Weight — ☐ st ☐ lb ☐ kg

15. Chest Girth – Inspiration — ☐ in ☐ cm

16. Chest Girth – Expiration — ☐ in ☐ cm

17. Abdominal Girth — ☐ in ☐ cm

18. Has the weight changed in the last year?

Yes ☐ No ☐ — If YES please provide full details

Please examine the following systems and report any abnormalities found.

19. Cardio-Vascular System

(a) Is there any abnormality?

Yes ☐ No ☐ — If any known abnormality, please give date and result of all investigations

(b) Is there any abnormality of the heart sounds and rhythm? Yes ☐ No ☐

(c) Please advise the position of the apex beat.

(d) 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)

(e) 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)*			

20. Respiratory System
Is there any abnormality in the respiratory movements and sounds?

Yes ☐ No ☐ — If there is evidence of past or present disease please record Peak Flow Rate

21. Nervous System

(a) What is the condition of the ears?

Please comment on hearing in both ears

(b) What is the condition of the eyes?

Please comment on vision in both eyes

(c) Are there any abnormalities of the reflexes, the motor or sensory systems?

Yes ☐ No ☐ — If YES please provide full details

(d) Are there any abnormalities of co-ordination?

Yes ☐ No ☐ — If YES please provide full details

22. Digestive Organs

(a) Is there any abnormality of the teeth, gums, tongue or throat?

Yes ☐ No ☐ If YES please provide full details

(b) Is there any abnormality of the abdomen apparent on palpation?

Yes ☐ No ☐ If YES please provide full details

(c) Is there any evidence of hernia?

Yes ☐ No ☐ If YES please provide full details

23. Musculo Skeletal

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

Yes ☐ No ☐ If YES please provide full details

24. Genito-urinary System

Is there any evidence of disease of the bladder or kidneys or any other part of the Urogenital System?
(Examination is not required)

Yes ☐ No ☐ If YES please provide full details

25. 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? Yes ☐ No ☐

(b) Is sugar present? Yes ☐ No ☐

(c) Is blood present? Yes ☐ No ☐

(d) Is there any other abnormality? Yes ☐ No ☐

If YES please provide full details

26. Female Lives

(a) Any history of an abnormal smear test/ mammogram or breast ultrasound? Yes ☐ No ☐

(b) Is there history of complications related to pregnancy? Yes ☐ No ☐

(c) Is she currently pregnant? Yes ☐ No ☐

If YES please provide full details

27. 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?

Signed:

Qualifications:

Date: D ☐☐ M ☐☐ Y ☐☐☐☐

Name and Address
(in capitals please, required for payment)

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