PACIS MEDICAL EXAMINATION FORM
MEDICAL EXAMINATION REPORT – STRICTLY CONFIDENTIAL
TO BE COMPLETED BY PATIENT BEFORE SEEING THE DOCTOR

1. a. Name _____ Sex _____

b. ID / Passport No. : _____D.O. B. (dd/mm/yr) _____

c. Postal Address _____Postal code _____Town_____E- Mail _____

d. Tel (office) _____ Res._____ Cell phone _____

e. Personal doctor if applicable _____ Tel _____

f. Corporate / Individual Membership (*indicate Corporate Name*) _____

g. Name of Agent/Broker _____

2. a. State whether you or any of your dependants have ever been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including but not limited to.

	CONDITION	YES	NO		CONDITION	YES	NO
1	Fits			17	Unexplained Fever		
2	Bronchitis/asthma			18	Pneumonia		
3	piles			19	Chest pain		
4	Heart problems			20	Severe Headaches		
5	Rheumatic fever			21	Severe indigestion		
6	Diabetes			22	Liver diseases		
7	Fainting/dizziness			23	Bladder/kidney dx		
8	Pleurisy			24	Skin disorders		
9	High BP			25	Mental/nervous D/o		
10	Rheumatism			26	Tuberculosis		
11	Renal Colic			27	Ear infections		
12	bleeding			28	defects		
13	Long standing Swellings			29	Uterine bleeding		
14	Eye Problems			30	Inability to pass Urine		
15	Breathlessness						
16	Lack of blood/anaemia						

b. Have you ever been treated with: -

☐ Steroids ☐ Antihypertensive drugs ☐ other chronic medications

c. Have you ever had or been advised to have a blood test for AIDS or AIDS-related condition?

d. Have you ever been refused as a blood donor?

e. Do you have any allergies to medicines?

f. Have you received a blood transfusion within the last 5 years?
Give details of all positive answers (space provided next page).

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Surgery and Hospital Admissions

Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you have undergone in the past, and /or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you expect to undergo in the future? More space below

Hospital/ Doctor	Surgical procedure/ hospital admission	Date	Diagnosis

2. _____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Marital status: married/single/separated/divorced/widowed_____

(Where applicable, cause of death of spouse)

Number of children _____ Profession/occupation _____

HABITS

Units of alcohol/sitting _____

No. of cigarettes/day _____ Duration of smoking _____

3. If female:-
   a) Menstrual cycle – duration, flow, abnormality _____
   b) Contraception history _____

4. Family history of any of the following diseases (please tick)

Ischemic heart disease ☐	Hypertension ☐	Bronchial asthma ☐	Allergic skin conditions ☐
Diabetes ☐	Mental disorder ☐	Sudden death ☐	Cancer ☐

DECLARATION:

I hereby apply to join the above mentioned plan. I understand that any mis-statements or non-disclosure of any material information in this form will jeopardize my membership. I warrant that the answers in this form are true, correct and complete and I acknowledge that such answers are all material.

I hereby authorize any doctor, hospital, clinic or medical provider, any company, institution or person who has record or information about me and/or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

Name: ……..…….…….. Signature: …….…… Date: ……..

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TO BE COMPLETED BY EXAMINING DOCTOR	YES	NO	COMMENTS
5. RESPIRATORY SYSTEM			
Any Previous history?	☐	☐	
Are there signs of decreased chest expansion?	☐	☐	
Are there signs of abnormal dullness to Percussion?			
Are there abnormal auscultatory signs?	☐	☐	
Is the voice normal?	☐	☐	
NECK: Is there evidence of goiter?	☐	☐	
	☐	☐	
6. CARDIOVASCULAR SYSTEM			
Previous history	☐	☐	
Is the heart enlarged?	☐	☐	
Are the heart sounds normal?			
(Intensity, splitting, etc)	☐	☐	
Are there any cardiac murmurs?			
IF APPLICABLE	☐	☐	
	☐	☐	
Does the murmur seem to be pathological?	☐	☐	
Does the murmur irradiate?			
Where is the maximal intensity?	☐	☐	
Does the abdominal aorta seem dilated?	☐	☐	
Are the peripheral pulses all present and			
Symmetrical?	☐	☐	
Are there any arterial bruits in the cervical	☐	☐	
and femoral regions?	☐	☐	

7. BLOOD PRESSURE

Systolic: _____mmhg/Diastolic: _____mmhg. With treatment ☐ without treatment ☐

Pulse rate: _____ Extra systoles _____

If the blood pressure more that 140/90, repeat and record._____. (3 serial recordings needed)

If the blood pressure is over 150/90 mmHg, please check the reading after ten minutes lying down.

Second reading: Systolic _____ Diastolic _____ Pulse rate _____

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	YES	NO	COMMENTS
8. GASTROINTENSTINAL SYSTEM	☐	☐	
Previous history?	☐	☐	
Are there any abnormalities of the mouth?	☐	☐	
Tongue, pharynx or tonsils?			
Are there any abnormalities of the abdomen?	☐	☐	
On palpitation?	☐	☐	
Hepatomegaly?			
Splenomegaly?	☐	☐	
Are there any abnormalities of the hernia?	☐	☐	
Orifices?			
Are there signs of hemorrhoids, previous melena or rectal bleeding?	☐	☐	
9. GENITO URINARY SYSTEM	☐	☐	
Previous history?			
For men:			
Are there any signs of disease of the genital Organs (testis, epididymis, prostate)?	☐	☐	
Is there gynaecomastia?	☐	☐	
For women:			
Are there any signs of disease of the genital organs?	☐	☐	
Are there any abnormalities of the breast?	☐	☐	
10. CENTRAL NERVOUS SYSTEM	☐	☐	
Any Previous history of CNS disease?	☐	☐	
Presence of any complications or sequellae?			
Are the papillary, abdominal or tendon Reflexes abnormal?	☐	☐	
Are there any signs of autonomic nervous Dysfunction?	☐	☐	
Are there any psychiatric or neurological Abnormalities noted?	☐	☐	
11. SKIN AND TEGUMENTS	☐	☐	
Are there any signs of?			
Jaundice or cyanosis?	☐	☐	
Skin eruptions, cyst, tumors, varicosities or	☐	☐	
Edema?	☐	☐	
Lymphadenopathy?	☐	☐	
Scars or tattoos?			
Tophi and exanthemata?			

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	YES	NO	COMMENTS
12. SKELETAL SYSTEM Are there any abnormalities of the bones, Joints, or intervertebral discs?	☐	☐	
13. SENSORY ORGANS Is there any disease of the eyes? Visual acuity? R L **Before correction** /10 /10 **After correction** /10 /10 Is there any disease of the ears?	☐ ☐ ☐	☐ ☐ ☐	
Is the examinee currently under medical Treatment?	☐	☐	which? Since when? Why?
Signature of the examinee……_Date……..			
14. CONCLUSIONS: Do you have any reservations concerning the Longevity of the examinee? Are there any risks on invalidity or Partial, or total disability?	☐ ☐	☐ ☐	
The proposer's state of health is Considered to be: **GOOD** **AVERAGE** **POOR**			

15. ADDITIONAL STANDARD MEDICAL TEST REQUIRED {√} INDICATE RESULTS

Random blood sugar		
Urinalysis		
Full Haemogram		
U&E		
HIV		
PSA		
Others as recommended by the doctor		

Consultants' review ……

Examiner's full names Dr._____

Signature _____ Date _____