

MEDICAL STATEMENT

DATE

NAME AND MAILING ADDRESS		PRODUCER NAME AND MAILING ADDRESS	
TELEPHONE NUMBER		TELEPHONE NUMBER	
POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED	

GENERAL INFORMATION				
DATE OF BIRTH	AGE	SEX	EMPLOYER'S NAME AND ADDRESS	OCCUPATION
NAME AND ADDRESS OF FAMILY DOCTOR			YRS UNDER PHYSICIAN CARE	DATE OF LAST VISIT

MEDICAL HISTORY: EXPLAIN ALL "YES" RESPONSES IN REMARKS - INCLUDE QUESTION NUMBER AND EXPLANATION

	YES	NO		YES	NO
EYESIGHT			DIABETES, continued		
1. HAVE YOU LOST USE/SIGHT OF EITHER EYE?	[]	[]	B. MEDICATION/DOSAGE USED:	_____	
2. IS PERIPHERAL (SIDE) VISION RESTRICTED?	[]	[]	C. METHOD OF ADMINISTRATION:	_____	
3. ARE YOU COLOR BLIND?	[]	[]	D. HAS INSURED EVER EXPERIENCED DIABETIC COMA OR INSULIN SHOCK?	[]	[]
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?	[]	[]	EPILEPSY		
5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?	[]	[]	20. HAVE YOU EVER BEEN TREATED FOR EPILEPSY?	[]	[]
6. DATE OF LAST EXAMINATION _____			A. IF YES, KIND AND DATE OF LAST SEIZURE:	_____	
HEARING			B. MEDICATION / DOSAGE USED:	_____	
7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL?	[]	[]	BLOOD PRESSURE		
8. IS HEARING AID USED?	[]	[]	20. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE?	[]	[]
HEART			A. IF YES, DATE OF LAST TREATMENT:	_____	
9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?	[]	[]	B. LAST READING:	_____	
10. HAVE YOU EVER HAD A HEART ATTACK?	[]	[]	C. MEDICATION/DOSAGE USED:	_____	
11. DO YOU HAVE A PACEMAKER?	[]	[]	MISCELLANEOUS		
12. MEDICATION/DOSAGE USED: _____			22. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR, MENTAL OR EMOTIONAL PROBLEM?	[]	[]
13. WHEN WAS THE LAST TREATMENT OR CHECK-UP? _____			23. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, ETC.)?	[]	[]
BACK			24. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENCE OTHER THAN GLASSES?	[]	[]
14. DO YOU HAVE A HISTORY OF BACK PROBLEMS?	[]	[]	25. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE	_____	
15. HAVE YOU EVER BEEN TREATED BY A PHYSICIAN / CHIROPRACTOR FOR A BACK PROBLEM?	[]	[]	A. CONVULSIONS:	_____	
A. IF YES, DATE OF LAST VISIT _____			B. FAINTING SPELLS:	_____	
B. DIAGNOSIS _____			C. LOSS OF EQUILIBRIUM:	_____	
LIMBS			D. ALCOHOL/DRUG ABUSE:	_____	
16. HAVE YOU LOST AN ARM OR LEG?	[]	[]	E. MENTAL/EMOTIONAL ILLNESS:	_____	
17. HAVE YOU LOST THE USE OF AN ARM OR LEG?	[]	[]	F. COMPLETE PHYSICAL EXAMINATION:	_____	
18. DOES CAR HAVE SPECIAL CONTROLS?	[]	[]	DIABETES		
DIABETES			19. HAVE YOU EVER BEEN TREATED FOR DIABETES?	[]	[]
19. HAVE YOU EVER BEEN TREATED FOR DIABETES?	[]	[]	A. LATEST BLOOD SUGAR TEST DATE:	_____	
A. LATEST BLOOD SUGAR TEST DATE: _____			28. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?	[]	[]

REMARKS:

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF THE FOREGOING STATEMENTS ARE TRUE.

X _____
physician's signature

X _____
SIGNATURE DATE