



EXAMINING PHYSICIAN'S CONFIDENTIAL REPORT

Examination is to be made in private and findings are to be treated confidentially.
Mail completed examination to Petersen International Underwriters, Lloyd's Correspondents,
23929 Valencia Blvd. # 215, Valencia, CA 91355, 1-800-345-8816 * Fax 661 254-0604 * E-mail piu@piu.org

1. a. Name _____		
b. How did you identify the person examined? _____		
b. Have you ever attended this applicant before?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. a. Age: _____ b. Does the applicant appear older?		<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Does appearance indicate health and vigor		<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Are you related to the person examined or the writing representative?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. a. HEIGHT: In shoes: _____ ft. _____ in.		Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. WEIGHT _____ pounds.		Did you weight? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. GIRTH		
Chest at forced inspiration _____ in.		
Chest at forced expiration _____ in.		
Abdomen _____ in.		
4. BLOOD PRESSURE		
	Systolic	Diastolic 5th Point Disappearance of Sound
1st Reading	_____	_____
2nd Reading	_____	_____
3rd Reading	_____	_____
5. PULSE		
	Pulse	Premature Contractions (Count pulse for one full minute)
a. At rest	_____	_____
b. Immediately after exercise	_____	_____
c. Three minutes after exercise	_____	_____
d. Is arrhythmia present?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe any irregularity: _____		
6. URINALYSIS		
Specific Gravity _____	Albumin _____ Test _____	Sugar _____ Test _____
Mail remainder of specimen to laboratory on all applicants.		
7. SMOKING		
Has Proposed Insured smoked cigarettes at any time within the past 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Used other tobacco products? (If "yes," describe)		<input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT: Are you sending, or have you arranged to send an X-RAY, BLOOD PROFILE or ELECTROCARDIOGRAM?

EKG: Yes No X-RAY: Yes No BLOOD PROFILE: Yes No

Examination made at: My office Applicant's residence Applicant's place of business

I CERTIFY that the above and the reverse side are a record of a careful examination on this date of the person described herein whose answers were recorded as given to me, and whose signature on the reverse side was written in my presence.

Date: _____ Time: _____ AM/PM

Please print or stamp your name and address:

Name _____

Address _____



ANSWERS MADE TO THE EXAMINING PHYSICIAN

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1. PROPOSED INSURED _____ Date of Birth: _____		DETAILS OF YES ANSWERS (Identify Questions numbers and circle all applicable items. Include diagnosis, dates, duration, and names and addresses of all physicians and medical facilities).
2. When did Proposed Insured last consult a physician? Date _____ Doctor/Address: _____ What treatment was given or recommended? _____		
3. Has any parent, brother, or sister ever had tuberculosis, diabetes, cancer, high blood pressure, heart disease, kidney disease, or mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Have you within the past five years:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
a. Been examined by or consulted a physician or other practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Been under the observation or treatment in a hospital, sanitarium or institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Had a x-ray, electrocardiogram, blood, urine or other laboratory tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Have you ever:		
a. Received benefits or compensation for sickness or injury or had life or disability insurance rated up, modified, rejected, cancelled or not renewed?		
b. Sought advice or treatment for or been arrested for or been addicted to the use of alcohol or drugs?		
c. Had any disease of the reproductive organs, genital organs, breasts, or any amputation or bodily deformity, hernia or rupture, hemorrhoids or varicose veins?		
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?		
6. Have you ever had or been treated for:		
a. Any disease or disorder of the eyes, ears, nose, throat, or thyroid gland?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Any deformity or disorder of the back, spine, muscles, bones or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Any allergies of any sort or disorders of the skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Chest pain, heart murmur, high blood pressure, or any other disease or disorder of the heart, circulatory system, blood, or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Peptic ulcer, indigestion, or any disease of the stomach, intestine, gall bladder, liver, pancreas, spleen, or enlarged lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Tuberculosis, asthma, pleurisy, or any other disease of the chest or lungs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Albumin, pus, blood or sugar in urine, urinary stone, or other disease of the kidneys, bladder or prostate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Severe headaches, fainting spells, dizziness, vertigo, syncope, epilepsy, paralysis, nervousness, mental disorder, or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
i. Rheumatic or other fever, syphilis, gout, arthritis, goiter, diabetes, cancer, tumor or disorder of the lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
j. AIDS (Acquired Immune Deficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus) or been told he/she had AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
k. Any surgical operation, treatment, or any illness, ailment, abnormality, or injury not mentioned above within the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Are you now under treatment or taking any prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Are you pregnant? (If "Yes," give date child is expected.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Are you aware of any other medical information not listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby declare that all the statements and answers to the above questions are complete and true to the best of my knowledge and belief, and I agree that the foregoing together with this declaration shall form a part, designated as Part III of the application for insurance.

Witness _____ M.D. X _____
Examining Physician Signature of person examined or applicant if child under age 16

Date _____