Cooperative Insurance System of the Philippines

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No. 80 Malakas St.
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Quezon City

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Full Medical Exam Report

Every question must be asked to the applicant by the Medical Examiner. The applicant's answers must be recorded in the examiner's own handwriting, in black ink. Examination must be done in private

1. 1. Life Proposed (Print Full Name) FIRST MIDDLE LAST	1.2. Birthdate	1.3. Race/ Nationality
	1.4. Birthplace	1.5. Civil Status
2. Name and Address of your personal physician? (if none, kindly state) a. Date and reason last consulted? b. What treatment was given or medication prescribed?	1.6 Home Address;	
	1.7 Occupation	

	YES	NO
3. Have you ever been treated for or had any known indication of: a. Disorders of eyes, ears, nose and throat?	☐	☐
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis and stroke, mental or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d. Chest palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis diverticulitis, hemmhoroids, recurrent indigestion, other disorders of the stomach, intestines, liver or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in the urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes, thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of the skin, lymph glands, cyst, tumor or cancer?	☐	☐
k. Allergies, anemia or other disorders of the blood?	☐	☐
l. Excessive use of alcohol, tobacco or any habit-forming drugs?	☐	☐
m. Any mental or physical disorder not listed above?	☐	☐
4. Are you currently under observation or taking any treatment?	☐	☐
5. Have you had any change in weight in the past year?	☐	☐
6. Other than above, have you within the past 5 years: a. Had a check up, consultation, illness or surgery?	☐	☐
b. Been a patient in a hospital, clinic, sanitarium or other medical facility?	☐	☐
c. Had electrocardiogram, x-ray, and other diagnostic test?	☐	☐
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐
7. Has any life insurance company ever refused your application for Insurance or for reinstatement of a lapsed policy or offered you a policy different from what you applied for? When and what company was this?	☐	☐
8. Have you had military service deferment, rejection or discharge because of physical or mental condition?	☐	☐
9. Have you ever requested or received pension benefits or payment because of injury, sickness or disability?	☐	☐
10. Family History: Tuberculosis, diabetes, cancer, high blood pressure Heart or kidney disease, mental illness or suicide?	☐	☐

	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Spouse				
Siblings				

On the space provided write all the DETAILS of "Yes" answers . Please Indicate the Question number/letter, (include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

11. For Women Only:
a. are you pregnant? If so, how many months? _____
b. date of last delivery? _____
c. date of last menstruation? _____ Regular _____ Irregular _____
d. History of abortions, miscarriages? _____
e. Have you passed menopause? _____
f. Have you ever had tumor or disease of the breast, uterus, ovaries,?
_____

I hereby attest that the above statement are true and correct to the best of my knowledge. I am aware that my statements herein are all part of my application for insurance and are made to induce Cooperative Insurance System of the Philippines to issue a policy or contract I applied for. Unless prohibited by law, (1) I hereby authorize any physician or other person to disclose any information pertaining to my health; and (2) I waive all provisions of law forbidding the disclosure of such information.

Signed at _____ this _____ day of _____, _____

_____	_____	_____
Signature of EXAMINING PHYSICIAN	Signature of APPLICANT-OWNER	Signature of LIFE PROPOSED

MEDICAL EXAMINER'S REPORT

TO THE MEDICAL EXAMINER:

1. This examination report once begun, becomes the property of the System and must not be destroyed or suppressed even if the applicant or anyone else offers to pay the examination fee in order to avoid having the report sent to the System.
2. Do not examine for the System anyone who is related to you and for an agent closely related to you?
3. Initial any corrections or alterations you make on the report. Do not erase.

12. a. abdominal circumference at umbilicus: _____ cm Height: ____ft ____ins
chest circumference in inspiration: _____ cm Weight: _____ lbs
chest circumference in expiration: _____ cm

b. did you weigh? _____ yes ____ no
c. did you measure? _____ yes ____ no
d. does he/she appear older than his/her age? _____ yes _____ no

13. a. Blood Pressure:

1st	2nd	3rd

Pulse rate/min: _____
_____ regular
_____ irregular

b. Exercise Test - perform only if there is suspicion of heart impairment or abnormal blood pressure.
(kindly ask the applicant to perform simple exercises consisting of at least 50 hops)

	at rest	Immediately after	3 mins. after
Blood Pressure			
Pulse Rate			

14. Upon examination did you notice any abnormality in the following systems:

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? ……..	☐	☐
b. Skin, lumph nodes, varicose veins, peripheral arteries? …..	☐	☐
c. Nervous system *(include reflex, gait, paralysis)*? ……..	☐	☐
d. Respiratory system? ……	☐	☐
e. Gastrointestinal system? ……	☐	☐
f. Genitourinary system? ……	☐	☐
g. Endocrine System? ……	☐	☐
h. Musculoskeletal System? (*include spine, joint, deformities amputations*)	☐	☐

15. Heart: Location of the apex beat: _____

	Yes	No
Enlargement ……		
Murmur/s ……	☐	☐
Dypsnea ……	☐	☐
Edema ……	☐	☐

16. Are there any hernias? Yes ☐ No ☐ Hemorrhoids ? Yes ☐ No ☐
17. Are you aware of any adverse medical history ? Yes ☐ No ☐
(a confidential report may be sent to the medical history)
18. Does the applicant look healthy to you? Yes ☐ No ☐
19. Does the applicant look older than the stated age? Yes ☐ No ☐
20. Are you in any way related to the applicant or agent? Yes ☐ No ☐
If yes, how?
21. How long have you known the applicant? _____

22. Urinalysis
a. Chemical: Specific gravity _____
Color _____
Albumin _____
Sugar _____
Other abnormalities _____
B. Microscopic
Cast _____
Leucocytes _____
Epithelial cells _____
RBC _____
Crystals _____

DETAILS of "YES" answers

I hereby certify that I made this examination in private at: My clinic ☐ Applicant's home ☐ Applicants office ☐ in _____

This _____ day of _____, _____ at _____ am/pm.

_____, M.D.
COMPLETE NAME OF MEDICAL EXAMINER

_____
SIGNATURE
License no: _____

Address: _____

_____

NAME OF CISP REPRESENTATIVE: _____

PLAN APPLIED FOR: _____

AMOUNT OF COVERAGE: _____