

MEDICAL EXAMINATION FORM

Swiss life insurance companies

Physician, stamp (exact address)

Company

Policy- / application no.

Please note

■ We ask **the physician** to go through these questions together with the applicant and fill in the answers himself / herself if possible.

■ Please use **block letters and write legibly**. Thank you.

■ Insurers are prohibited by law from requesting the results of antenatal or **presymptomatic genetic tests** (testing to see whether a person is predisposed to illness before symptoms appear) unless certain conditions are met. If the preconditions for the right to ask questions are met, the investigation shall be carried out by using a separate form. Therefore, such findings do not have to be specified in the present questionnaire. Results which are voluntarily submitted may not be used by the insurers.

Genetic examinations for diagnostic purposes, i.e. to clarify symptoms of illness which have already occurred, are not affected by this legal provision and must be declared.

Applicant's personal details

Surname, first name Date of birth Description of the current occupation

Address Postcode City Country

No. Questions

No Yes Give all details

01	Do you exercise or practise sport regularly?	<input type="checkbox"/> <input type="checkbox"/>	Which? How often?
02	Have you consumed or smoked tobaccos or nicotine in any other form in the past 3 years?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Cigarettes <input type="checkbox"/> E-Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Something else (e.g. water pipe, chewing tobacco, nicotine patch) What? Daily amount? When was the last time?
03	Do you drink alcohol?	<input type="checkbox"/> <input type="checkbox"/>	Which drinks? How much? How often?
04	Are you or have you been, in the last 10 years, in consultation or treatment in connection with your consumption of alcohol (incl. special clarifications / examinations / advising centre)?	<input type="checkbox"/> <input type="checkbox"/>	When? By whom? Name and address
05	Do you take drugs or have you taken any in the past 10 years?	<input type="checkbox"/> <input type="checkbox"/>	Which? How often? How long? When was the last time?
06	Do you take medication regularly or repeatedly or have you done so in the past 5 years or have been described medications in the same period?	<input type="checkbox"/> <input type="checkbox"/>	Which? How often? Why? From when to when?
07 a.	Do you currently present any illnesses / health conditions / consequences of accidents?	<input type="checkbox"/> <input type="checkbox"/>	Which?
b.	Is your ability to work or gain income limited in any way?	<input type="checkbox"/> <input type="checkbox"/>	Why? Since when? Degree / Extent?
c.	Have you been completely or partially unable to work without interruption for more than 4 weeks during the last 5 years?	<input type="checkbox"/> <input type="checkbox"/>	Why? From when to when?
d.	Did you ever apply for any medical, educational, professional or other measures at an insurance?	<input type="checkbox"/> <input type="checkbox"/>	Which insurance? When? Why?
08	Have your parents, siblings or grandparents had any diseases of the nervous system, cardiac diseases, strokes, diabetes, cancer or hereditary diseases before the age of 55?	<input type="checkbox"/> <input type="checkbox"/>	Which disease(s)? How many persons?

Date and signature of the applicant

Date Signature

No.	Questions	No	Yes	Give all details				
09	Do you or did you have, in the last 10 years, any diseases, disorders or problems connected with			Which?	When?	Duration?	Cured?	Physicians/other therapists with addresses:
	a. the respiratory organs , such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other problems?	<input type="checkbox"/>	<input type="checkbox"/>					
	b. the heart or vascular system , such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, cardiac dysrhythmia, stroke, phlebitis, varicose veins or other problems?	<input type="checkbox"/>	<input type="checkbox"/>					
	c. the digestive system , such as hiatus hernia, gastric or intestinal ulcer/inflammations/haemorrhages, haemorrhoids, jaundice, diseases of the liver, gall bladder, pancreas or other problems?	<input type="checkbox"/>	<input type="checkbox"/>					
	d. the urinary tract or sexual organs , such as diseases of the kidneys, ureters, bladder, prostate or testicles, uterus or ovary diseases, illnesses of the female breast, kidney/bladder stones, blood or protein in the urine or other problems?	<input type="checkbox"/>	<input type="checkbox"/>					
	e. the nervous system , such as epilepsy, dizziness, headache, paralysis, neuritis or other problems?	<input type="checkbox"/>	<input type="checkbox"/>					
	f. the mental state , i.e. mental disorders such as depression, anxiety, stress, eating or psychosomatic disorders or other problems?	<input type="checkbox"/>	<input type="checkbox"/>					
	g. the musculoskeletal system (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons), such as disorders of the back, neck or shoulders, arthrosis, rheumatism or other problems?	<input type="checkbox"/>	<input type="checkbox"/>					
	h. the eyes , such as decreased visual acuity or refraction power, cataract (lens opacity) or glaucoma, retinal disease or other disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Diopters: left _____ / right _____				
	i. the ear , such as hearing difficulties, inflammation, tinnitus or other disorders?	<input type="checkbox"/>	<input type="checkbox"/>					
	j. the metabolism or blood , such as diabetes mellitus, elevated cholesterol, gout, hormonal disturbances (thyroid gland, adrenal glands), anaemia, coagulation disturbances or other disorders?	<input type="checkbox"/>	<input type="checkbox"/>					
	k. the immune system or infectious diseases , such as HIV infection, sexually transmitted diseases, hepatitis, Lyme disease, tropical diseases or other disorders?	<input type="checkbox"/>	<input type="checkbox"/>					
	l. other illnesses, disorders or problems not listed above (e.g. skin diseases, allergies, benign or malignant tumors, congenital defects, deformities, burn out etc.)?	<input type="checkbox"/>	<input type="checkbox"/>					
10	Have you ever attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>					
11	Are there medical consultations or treatments, a hospital stay or any surgery currently planned or recommended?	<input type="checkbox"/>	<input type="checkbox"/>	Why?				
12	Have you consulted any physicians, chiropractors, osteopaths, physiotherapists, psychotherapists or other medical experts in the last 5 years that have not already been mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	Names and exact addresses	Why?	When?	Cured?	
13	Which physician did you last consult?	⇒		Name and exact address				
		⇒		Why?	When?	Results?		
14	Which physician is most familiar with your medical history?	⇒		Name and exact address				

I hereby declare that I have answered the above questions 1 to 14 honestly and completely. The validity of the contract depends on the questions being answered correctly and completely. I authorise any doctors, medical institutions and insurance bodies approached by the company to provide any information necessary for consideration of the application.

Place	Date	Signature of the applicant
<input type="text"/>	<input type="text"/>	<input type="text"/>

I hereby confirm that I have handled each question above together with the applicant.

Place	Date	Signature of the physician
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medical evaluation of case history:

Medical examination including urinalysis

Please indicate and detail all pathological or abnormal findings. Thank you.

No. Questions

No Yes Give all details

15 a. Date of medical examination:	<input type="checkbox"/>	<input type="checkbox"/>	⇒ <input style="width: 80px;" type="text"/>
b. Do you personally know the person to be insured?	<input type="checkbox"/>	<input type="checkbox"/>	Personally known since: <input style="width: 80px;" type="text"/> Identity checked on the basis of: <input type="checkbox"/> Passport <input type="checkbox"/> ID <input type="checkbox"/> Driving licence <input type="checkbox"/> Residence permit
c. Have you yourself previously examined or treated the applicant?	<input type="checkbox"/>	<input type="checkbox"/>	When? Why? Results?
16 Height (without shoes) / Weight (without clothes)	<input type="checkbox"/>	<input type="checkbox"/>	⇒ <input style="width: 60px;" type="text"/> cm <input style="width: 60px;" type="text"/> kg Abdominal <input style="width: 60px;" type="text"/> cm Hip <input style="width: 60px;" type="text"/> cm girth measurement
If overweight (BMI > 25)	<input type="checkbox"/>	<input type="checkbox"/>	⇒
17 Skin Are there any signs of skin disease or scars?	<input type="checkbox"/>	<input type="checkbox"/>	
18 Respiratory Organs a. Are the results of percussion and auscultation abnormal?	<input type="checkbox"/>	<input type="checkbox"/>	Cause?
b. Are there any signs of disease of the respiratory organs?	<input type="checkbox"/>	<input type="checkbox"/>	
19 Heart and Circulation a. Is there a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	If yes: <input type="checkbox"/> systolic <input type="checkbox"/> diastolic Point of maximum intensity and transmission? ⇒
Is the heart murmur pathological?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Are there audible carotid murmurs?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Pulse rate, blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	⇒ Beats per minute <input style="width: 80px;" type="text"/> ⇒ Blood pressure in mmHg <input style="width: 80px;" type="text"/> / <input style="width: 80px;" type="text"/> systolic diastolic Please repeat measurement if the result is over 135/85 mmHg ⇒ Blood pressure, 2nd reading <input style="width: 80px;" type="text"/> / <input style="width: 80px;" type="text"/>
d. Pulse rhythm	<input type="checkbox"/>	<input type="checkbox"/>	⇒ <input type="checkbox"/> regular <input type="checkbox"/> irregular
e. Are there audible vascular sounds?	<input type="checkbox"/>	<input type="checkbox"/>	Where?
f. Is pulsation of the pedal arteries absent or diminished?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Are there any signs of insufficiency or decompensation (shortness of breath, cyanosis)?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Are there any varicose veins or signs of chronic venous insufficiency?	<input type="checkbox"/>	<input type="checkbox"/>	

Date and signature of the physician

Date

Signature

No.	Questions	No	Yes	Give all details
20	Digestive Organs and Abdomen			
	a. Are there any abnormalities of the teeth, tongue, tonsils, mucous membrane or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Are there any abnormalities on examination, palpation, percussion and auscultation of the abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	
	c. Is there a hernia?	<input type="checkbox"/>	<input type="checkbox"/>	
21	Urinary Tract and Sexual Organs			
	a. For male applicants: Is there any suspicion of disease of the urinary tract or sexual organs?	<input type="checkbox"/>	<input type="checkbox"/>	
	b. For female applicants: Is there any suspicion of disease of the urinary tract or sexual organs, pathological breast abnormalities or is the applicant pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
22	Nervous System / Sense Organs			
	a. Are there any signs of disease of the sense organs, particularly diminished sight or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Are there any indications of neurological diseases, disorders or insufficiencies e.g. motor function, reflexes, sensitivity, balance?	<input type="checkbox"/>	<input type="checkbox"/>	
23	Psyche			
	Are there any recognisable psychological or mental abnormalities (e.g. inappropriate moodiness or abnormal behaviour) or are there indications that there are currently stressful situations or conflicts?	<input type="checkbox"/>	<input type="checkbox"/>	
24	Musculoskeletal System			
	Are there signs of spinal disease or deformations or any other diseases of the musculoskeletal system?	<input type="checkbox"/>	<input type="checkbox"/>	
25	Other			
	a. Are there any enlarged lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	Where?
	b. Are there any indications of endocrinological disorders?	<input type="checkbox"/>	<input type="checkbox"/>	
	c. Is there any suspicion of eating disorders, alcohol abuse or drug use?	<input type="checkbox"/>	<input type="checkbox"/>	
	d. Were there any other findings that could increase the risk level?	<input type="checkbox"/>	<input type="checkbox"/>	
26	Urine test			
	Result of urinalysis (please provide quantitative information)	<input type="checkbox"/>	<input type="checkbox"/>	⇒

Comments:

(further conclusions, e.g. risk factors, suggestions for examinations and / or therapy)

Please enclose copies of available examination findings. Thank you.

I hereby confirm that I have questioned and examined the applicant and have answered the above questions 15 to 26 to the best of my knowledge and in good faith.

Place

Date

Signature of the physician