



RASTRIYA BEEMA SANSTHAN

MEDICAL EXAMINER'S REPORT

This Report is a strictly confidential and Statement and the Medical Examiner is asked to forward it direct to the Company and not to communicate its contents to the applicant or to any other unauthorized person.

CLIENT'S NAME :

1. Do you know the proposer ? If so, since when	
2. Has the proposer ever been attended to by you ? If so, when and why ?	
3. GENERAL APPEARANCE (a) Does the proposer's appearance correspond to the age stated ? (b) Is there any deformity, any abnormal spinal curvature, any abnormality of growth any mutilation or scar of operation ? If so, give particulars. (c) Have you any reason to suspect intemperance in the consumption of alcohol, cigarettes or the use of narcotics ?	(a) (b) (c)
4. BUILD (a) Height by measuring (c) Chest at deep inspiration Chest at forced expiration	(b) Weight by weighing (d) Abdominal girth
5. CIRCULATORY SYSTEM (a) In which intercostal space is the apex beat palpable ? (b) Is there evidence of cardiac enlargement or displacement ? (c) Is there evidence of dyspnoea, cyanosis or oedema ? (d) Pulse rate per minute, Is the Pulse regular	(a) (b) (c) (d) If not, state irregularities per minute at rest after exercise

(e) Blood pressure Systolic (1) (2) (3)
 (Please record
 3 readings Diastolic
 (5th phase

(f) Is there a heart murmur ? If so, please describe below :

- | | | | |
|-------------------------|--------------------------------------|--------------------------------------|--|
| (i) Location: | apical area <input type="checkbox"/> | aortic area <input type="checkbox"/> | pulmonic area <input type="checkbox"/> |
| (ii) Timing: | systolic <input type="checkbox"/> | diastolic <input type="checkbox"/> | presystolic <input type="checkbox"/> |
| (iii) Transmission: | neck <input type="checkbox"/> | axilla <input type="checkbox"/> | scapula <input type="checkbox"/> |
| (iv) Is Murmur: | constant <input type="checkbox"/> | inconstant <input type="checkbox"/> | |
| (v) Effect of exercise: | <input type="checkbox"/> | increased <input type="checkbox"/> | absent <input type="checkbox"/> |
| | | decreased <input type="checkbox"/> | unchanged <input type="checkbox"/> |

6. RESPIRATORY ORGANS
(a) Is the result of percussion normal ?
If not, please give details
(b) Is the result of auscultation normal ?
If not, please give details
(c) Is there any evidence of disease of the respiratory organs ?
If so, please describe

7. DIGESTIVE ORGANS
(a) Do palpation and percussions suggest any pathological changes of the abdomen or is there tenderness or pressure over the epigastrium ?
If so, please give details.
(b) Is there evidence of enlargement of the liver and / or spleen ?
(c) Is there any hernia ?
(d) Condition of teeth ?

8. GENITO URINARY ORGANS
(a) Urinalysis (the urine should be passed in the presence of the Medical Examiner)
(b) Is there any suspicion of disease of the sexual organs (testes, epididymides, prostate gland) ?

9. EYES AND EARS
Is there any disease of the eyes or ears ?
If so, please describe and indicate whether uni or bilateral.

10. NERVOUS SYSTEM
Is there any suspicion of mental or neurological disorder ?

11. SKIN AND BONES
(a) Is there any evidence of skin disease ?
(b) Is there any evidence of disease of the bones or joints ?

12. MODE OF LIVING
Is the proposer's occupation or mode of living likely to be detrimental to his health ?

13. SPECIAL REMARKS
Please state your reasons :

I hereby declare that I have today examined the Proposer and have answered the foregoing questions to the best of my knowledge and belief.

Dated at this day of 20

Medical Examiner's Name Qualification

Medical Examiner's Signature :

Address :

Signature of the Proposer :

(To be signed in the presence of the Medical Examiner)