**MEDICAL EXAMINATION FORM**

Proposal No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father/ Husband Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CNIC No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mark of identification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Build Measurement**
2. Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cm
3. Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Kg
4. Abdominal Girth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cm
5. Chest Measurement\_\_\_\_\_\_\_\_\_\_\_\_Cm
6. **Habits**
7. Alcohol Consumption\_\_\_\_\_\_per week
8. Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Since Less than one year
10. Tobacco Consumption\_\_\_\_\_\_\_\_\_\_per day Cigarette Cigar Tobacco

More than one year

1. **Circulatory System**
2. Bloood Pressure: (3 readings)
* Systolic\_\_\_\_\_\_Diastolic\_\_\_\_\_\_mm Hg
* Systolic\_\_\_\_\_\_Diastolic\_\_\_\_\_\_mm Hg
* Systolic \_\_\_\_\_\_Diastolic\_\_\_\_\_mm Hg
1. Pulse\_\_\_\_\_\_\_\_\_per minute
2. Regular Irregular
3. Is there any evidence of cardiac enlargement?
4. Is there any abnormality in the heart sounds or rhythm?
5. Is the examinee now on treatment for Ischemic Heart Disease, Hypertension or Hypercholesterolemia or any other Heart Disease or Condition?

If yes to any of above queries then please give details with the medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Respiratory System**
2. Is he/ she suffering from Tuberculosis, Asthma or any other Respiratory ailment?

YES /NO

If yes please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Digestive and Lymphatic System**
2. Is there any abnormality of mouth, teeth or throat?
3. Is any tooth missing?
4. Is there any abnormality of abdominal organs, including Stomach, Intestine,

 Kidney, Pancreas, Liver or Spleen?

1. Is he/ she or was suffering from Hepatitis (any type)?
2. Is there any abnormality of the Lymph nodes in the neck, axillae or inguinal regions?

If yes to any of above queries then please give details with the medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Endocrine**
2. Is he / she or any of his / her family members suffering from Diabetes Mellitus, Thyroid

 Or any other Endocrine abnormality?

1. If yes cause: By Birth Acquired
2. Family member: Parents Brothers Sisters

Any other detail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Miscellaneous**
2. Is there any defect in Eye Sight?

If yes, cause of defect: By Birth Acquired Nature of defect\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there any defect in hearing or speech?

If yes, cause of defect: By Birth Acquired

1. Is there any evidence of mental abnormality?

If yes please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **For females only**
2. Is she pregnant? If yes please give EDD?
3. Is she suffering from any female organ disease or Gynecological disorder?

If yes please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Summary**
2. From all points of view do you recommend this life for Takaful coverage?
3. Is he / she looks healthy?
4. How old he / she looks?
5. If there is any sign of the following please specify:
6. Anemia
7. Jaundice
8. Cyanosis
9. Breathlessness
10. Obesity
11. Clubbing
12. Do you consider any special test is required? (No special test be carried out in connection with the proposal for Takaful coverage with out the company’s approval)

If yes please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Comment fully on any un-favorable features (physical or mental) which could influence the decision of the underwriter:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated at\_\_\_\_\_\_\_\_\_\_\_\_:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the Medical Examiner & stamp\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Medical Examiner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address & Tel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorised\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_