PHYSICIAN EXAMINATION REPORT

LMG PACIFIC HEALTH CARE
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Tel. : 0-2401-9160 Fax. : 0-2401-9161 E-mail : sales@lmgpacific.com

PART I (TO BE FILLED OUT BY THE APPLICANT)

Name: Last _____ First _____ Middle _____

Address: _____

Tel: _____ Fax: _____ E-Mail: _____

Date of Birth (MM/DD/YY) _____ Age: _____ Sex: _____

Country of Citizenship: _____ Country of Residence: _____

Father's Name: _____ Mother's Name: _____

If Deceased, Cause of death: _____ If Deceased, Cause of Death: _____

No. of Siblings: _____ If Any sibling is Deceased, cause of Death: _____

Medical Coverage: YES ☐ NO ☐

This note gives the physician permission to report any medical information requested to Pacific International Insurance Co., Ltd. Or its administrators.

Applicant's Signature: _____ Date: _____

PART II (TO BE FILLED OUT BY PHYSICIAN)

II-A MEDICAL QUESTIONAIRE (Mark "Yes" or "No" and circle the specific item)

	YES	NO		YES	NO
1. Weight loss/weight gain over the past year	☐	☐	6. Frequent/painful urination, flank pain hematuria, kidney stones, prostate problems	☐	☐
2. Recurrent headaches, dizziness, seizure, TIA CVA, localized weakness or paresthesias,	☐	☐	7. Abnormal vaginal discharge, bleeding, pelvic pain, painful/abnormal menstruation, breast nodules or tenderness	☐	☐
3. Visual complaints, ENT complaints, epistaxis, decreased hearing, tinnitus	☐	☐	8. Joint pain, arthritis, muscle pain, low back pain, claudication, paresthesias, cramps, edema	☐	☐
4. Recurrent abdominal pain, GERD, change in bowel habits and color of stool, hematemesis, hematochezia or melena	☐	☐	9. Ecchymoses, petechiae, easy bruising, gum or nose bleeding, icterus, rashes	☐	☐
5. Chest pain, palpitations, shortness of breath easy fatigability, orthopnea , CHF paroxysmal nocturnal dyspnea	☐	☐	10.Asthma, COPD, chronic cough, bronchitis, bloody sputum, urticaria, allergies,	☐	☐

Details: _____

ADDITIONAL INFORMATION:

_____

SOCIAL HISTORY:	YES	NO	
SMOKING	☐	☐	Amount: _____
ALCOHOL INTAKE	☐	☐	Amount: _____
ANY FORM OF EXERCISE	☐	☐	Details: _____

FAMILY HISTORY:

_____

_____

_____

PAST MEDICAL HISTORY (hospitalization, previous illness, etc.):

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

II-B PHYSICAL EXAMINATION REPORT: (Please comment on each area)

1. VITAL SIGNS: BP: _____ HR: _____ /MIN RESP: _____ TEMPERATURE: _____ º C
   HEIGHT : _____ CM WIEGHT: _____ KG
2. HEENT: EYES _____
   NECK/THROAT _____
   EARS _____
3. LUNGS: _____
4. HEART: _____
5. ABDOMEN: _____ SCARS: _____ RECTAL: _____
6. EXTREMITIES: _____ BACK: _____
7. NEURO: _____

DIAGNOSTIC TEST RESULTS: (copies of relevant results are required)

A: CHEST X-RAY: _____

B: 12LEAD ECG: _____

C: ROUTINE URINALYSIS (MICRO): _____

D: COMPLETE BLOOD COUNT (CBC): _____

E: LIPID PROFILE: _____

F: LIVER FUNCTION TEST: _____

G: KIDNEY FUNCTION TEST: _____ H: FASTING BLOOD SUGAR: _____

I: HEMOGLOBIN A1C: _____ J: PSA (MALE): _____

K: HEP TEST (B+C): _____ L: C-REACTIVE PROTEIN: _____

M: STOOL (OCCULT BLOOD): _____ N: PAP SMEAR (for female): _____

O: BILATERAL MAMMOGRAPHY /ULTRASOUND (for female): _____

ADDITIONAL TEST RESULTS (to be done if indicated): (copies of relevant results are required)

☐ 2-D ECHO CARDIOGRAM WITH DOPPLER: _____

☐ TREADMILL STRESS TEST: _____

☐ URINALYSIS (C&S): _____

☐ OTHER TEST: _____

IMPRESSION:

_____

_____

_____ _____ M.D.

Date Signature Over Printed Name