WrLife

PARTICIPATIVE INTERNATIONAL MEDICAL INSURANCE

Mutualist, affordable, ethical

Physician Examination Report

Part 1 (To be filled by the applicants)

Applicant Full Name_____

Age_____ Sex_____ Height_____ Weight_____

I authorize such medical provider to release the result of my medical examination to WRLife

Applicant's Signature _____ Date _____

Part 2 (To be filled by Physician)

Health Questionnaire: Have you had any of the following

	Yes	No
1. A lump or growth of any kind; or any mole or freckle that has bled, painful, changed color or increased in size?		
2. Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol?		
3. Recurrent headache, seizure, fainting or blackout?		
4. Any disorder of the digestive system, liver, stomach, pancreas or bowel - including gastric or duodenal ulcer hepatitis, colitis or Crohn's disease?		
5. Frequent/painful urination or any disorder of kidney, bladder or prostate - including blood or protein in the urine; or urinary tract infection?		
6. Blood disorder or anemia?		
7. Any disorder of the adrenal, pituitary or thyroid glands		
8. Asthma, COPD, bronchitis, chronic cough, allergies or any other disorder of the lung or respiratory system?		
9. Any pain or other disease, disorder or problem relating to your back, neck, joints, bones or muscles including arthritis, slipped disc, rheumatism or gout, edema?		
10. Any form of mental illness including anxiety, depression, stress, nervous breakdown or eating disorders?		
11. any gynecological disorder (including cervical smear) or breast condition for which you have been referred to a specialist or required investigations or treatment		
12. Have you ever tested positive for HIV/ AIDS, Hepatitis B or C or are you awaiting for the result of such test?		

If you have answered yes to any questions, please give detail below;

Disease/ Disorder:
Treatment/ Procedure:
Treated date/ Hospital:

Social History

Social History	Never	Occasionally	Sometimes	Often	Always
Smoking					
Alcohol Intake					
Any form of exercise					

Family History:

Past Medical History:

Current Medications:

Physical Examination

Vital Signs:	T	HR	BP	RR	O2	Height	Weight

HEENT:	
Eye	
Neck/ Throat	
Ear	

LUNG:	
HEART:	
ABDOMEN:	
EXTRIMITIES:	
NEURO:	

Diagnostic Test Results (Copies of relevant results are required)

CHEST X-RAY	
EKG	
ROUTINE URINALYSIS	
CBC	
HEPATITIS TESTING (A,B,C)	
LIPID PROFILE	
URIC ACID	

LIVER FUNCTION TEST (SGOT, SGPT, ALP)	
KIDNEY FUNCTION TEST (BUN, Creatinine)	
FASTING BLOOD SUGAR	
HEMOGLOBIN A1C	
PSA	
STOOL	
C-REACTIVE PROTEIN	
BILATERAL MAMOGRAPHY/ ULTRASOUND	

IMPRESSION

I hereby certify that I have made this examination private at_____

Date_____ Time_____

_____

( )

Signature of medical examiner

_____

M.D. License Number