Confidential Medical Examination Report

This report is to be completed by the medical attendant.

Please complete all sections.

Please ensure that a clear and complete answer is given to each of the questions in this report.

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On the medical condition of	Date of birth *(dd/mm/yyyy)*		
Address	Suburb	State	Postcode

PLEASE NOTE: Information regarding your findings should NOT be given to any other person. Exception may be made to the examinee's consent, if in your opinion there is medical information which should be conveyed to his/her medical attendant. The Company's decision concerning the application for insurance will be based on a careful consideration of the medical evidence and other factors including the type of insurance sought. The EXAMINER is therefore requested NOT to express to the examinee any opinion concerning the examinee's insurability.

Section 1. Introduction

1. Are you acquainted with the examinee

a) Professionally? ☐ Yes ☐ No	If Yes, please give details	
b) Personally? ☐ Yes ☐ No	If Yes, please give details	

2. Is there anything abnormal in appearance, development or behaviour?

☐ Yes ☐ No	If Yes, please give details

3. Is there any indication of past or present abuse of alcohol or of the misuse of drugs?

☐ Yes ☐ No	If Yes, please give details

Section 2. Measurements

Give the following measurements

1. a) Height (without shoes) cm | b) Weight (clothed) kg

2. Chest (middle of sternum) and abdomen (at umbilicus)

a) Chest expiration	b) Chest inspiration	c) Abdomen
cm	cm	cm

3. If chest expansion is less than 5cm, comment as to apparent cause or provide peak flow metre reading if available

Section 3. Respiratory system

1. Is there any sign of abnormality of the respiratory system to palpation, percussion or auscultation?

☐ Yes ☐ No | If Yes, please give details

2. Is there any sign of past or present respiratory disease?

☐ Yes ☐ No | If Yes, please give details

Section 4. Circulatory system

1. What is the rate and character of pulse?

Pulse rate	Character
per minute	

2. What is the position of the apex beat of the heart?

In the interspace, cm from the mid-sternal line

3. Is there any evidence of cardiac enlargement?

☐ Yes ☐ No | If Yes, please give details

4. Is there any abnormality in the heart sounds or rhythm?

☐ Yes ☐ No | If Yes, please give details

5. Is any murmur present?

☐ Yes ☐ No | If Yes, describe fully, including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur.

Section 4. Circulatory system (continued)

6. What is the Blood Pressure (Auscultatory method)? The diastolic level is to be taken at the cessation of all sound. If the first Systolic reading is above 135 or below 100, or the Diastolic above 85 or below 60, two further readings at 5 to 10 minute intervals are required. The recumbent position should be used where possible.

Systolic	Diastolic
	mm Hg
	mm Hg
	mm Hg

7. Is there any abnormality of the peripheral arterial or venous circulation?

☐ Yes ☐ No | If Yes, please give details

8. Do you consider the heart and vascular system to be **abnormal?**

☐ Yes ☐ No | If Yes, please give details

9. Is the examinee now on treatment for hypertension? ☐ Yes ☐ No

If known, please state

a) Pre-treatment blood pressure level including date

Systolic	Diastolic	Date

b) Duration of treatment

c) Nature of treatment

Section 5. Digestive and Lymphatic system

1. Is there any abnormality of tongue, mouth or throat?

☐ Yes ☐ No | If Yes, please give details

2. Is there any abnormality or evidence of disease of any abdominal organ, including liver and spleen?

☐ Yes ☐ No | If Yes, please give details

3. Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions?

☐ Yes ☐ No | If Yes, please give details

4. Is a hernia present?

☐ Yes ☐ No | If Yes, please give details

Section 6. Genito-Urinary system

1. Examination of the urine

a) Albumin	b) Glucose	c) Blood

If albumin is found, an early morning specimen should be examined and findings recorded before completing report.

Was the urine passed at the time of examination? ☐ Yes ☐ No

If not, please state circumstances

2. Is there any evidence of abnormality of the genito-urinary system?

☐ Yes ☐ No | If Yes, please give details

3. Females: Is the examinee pregnant?

☐ Yes ☐ No | If Yes, please give expected date of confinement

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Section 7. Nervous system

1. Is there any defect of vision or abnormality of the eyes?

☐ Yes ☐ No | If Yes, please give details

2. Is there any defect in hearing or speech?

☐ Yes ☐ No | If Yes, please give details

In cases of present or past ear discharge or deafness, state result of auriscopic examination

3. Is there any evidence of

a) Mental abnormality? ☐ Yes ☐ No | If Yes, please give details

b) Any disorder of the central or peripheral nervous system? ☐ Yes ☐ No | If Yes, please give details

Section 8. Musculo-Skeletal system and skin

1. Is there any abnormality of the form or function of

a) The joints? ☐ Yes ☐ No | If Yes, please give details

b) The muscles or connective tissues? ☐ Yes ☐ No | If Yes, please give details

c) The back or neck including the cervical and lumbar spine? ☐ Yes ☐ No | If Yes, please give details

2. Is there evidence of any disorder of the skin?

☐ Yes ☐ No | If Yes, please give details

Section 9. Summary

1. Do you consider any medical attendants' reports or any special tests are required? (No special tests are to be carried out in connection with the application for insurance without the Company's authority) ☐ Yes ☐ No

2. Do you consider the person examined to be likely to require any surgical operation? ☐ Yes ☐ No

3. Comment fully on any unfavourable features (either physical or mental) which could either reduce life expectancy or cause disablement
   a) In the personal or family history; or
   b) Disclosed by your examination

Section 10. Declaration

I have reviewed the examinee for the purpose of insurance assessment and discussed the applicant's personal and family history where I considered it appropriate.

Signature of medical examiner

Date *(dd/mm/yyyy)*

Provider no.

Qualifications

Phone no. (W)

Payment fee - Please fill bank account details

BSB

Account no.

Account name

IMPORTANT - This Medical Examination is a matter of importance to the person you have just examined and it would be appreciated if you would forward the report without delay.

Please return completed form to
Underwriting Services MetLife Insurance Limited, GPO Box 4528 Sydney NSW 2001
or email auservices@metlife.com
If you require assistance with the completion of this form, please call us on 1300 555 625
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