

The Examining Doctor must fill in all answers

Current State of Health

Are you in good health? <input type="checkbox"/> No <input type="checkbox"/> Yes	Why?
Have you often been given sick leave? <input type="checkbox"/> No <input type="checkbox"/> Yes	Why?
Indicate your present weight Kg Height , m.	
Indicate the present reading of your blood pressure - Max.	Min.

Personal History

Mark with an X if the candidate suffers or has suffered from any the following disturbances or diseases:

	No	Yes		No	Yes
Cardiovascular diseases (e.g. arteriosclerosis, coronariopathy, cardiac insufficiency, arrhythmia, hypertension - indicate previous reading, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory diseases (e.g. pleurisy, asthma, bronchitis, CPCD, emphysema, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Blood diseases (e.g. anaemia, leukaemia, lymphoma, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Infectious diseases (e.g. tuberculosis, hydatidosis, AIDS, venereal diseases, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine and metabolic diseases (e.g. diabetes, goitre, hyperlipidemia, hyperuricaemia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Muscular-skeletal diseases (e.g. curvature of the spine, spondyloarthritis, rheumatism, arthritis, gout, slipped disc, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal diseases (e.g. peptic ulcer, dyspepsia, colitis, diarrhoea, hernia)	<input type="checkbox"/>	<input type="checkbox"/>	Eyes, ears and pharynx diseases (e.g. cholesteatoma, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Liver, pancreas and gall bladder diseases (e.g. hepatitis, cirrhosis, lithiasis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases (e.g. eczema, leucoplakiz, lupus, allergies, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Urinary and prostate diseases (e.g. nephritis, renal insufficiency, albuminuria, haematuria, lithiasis, infections, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Physical disability? Professional diseases? (Specify)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological and mental diseases (e.g. epilepsy, stroke, paralysis, neuroses, psychoses, suicide attempts, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Surgical operations?	<input type="checkbox"/>	<input type="checkbox"/>
Bening or malign tumours (specify)	<input type="checkbox"/>	<input type="checkbox"/>	Others not specified here?	<input type="checkbox"/>	<input type="checkbox"/>

If you marked any of the above boxes, please indicate the following:

Organ or system	Duration	Date of occurrence	Year of cure	Treatment	Present state

Gynaecological or obstetrical history

Specify diseases of the uterus, ovaries or the breast, abortions, ectopic pregnancies, caesareans or others. If pregnant, specify time of gestation and any anomaly. _____

Habits

Tobacco - n° cigarettes/day	For how many years
Alcohol - type of drink	gr/alcohol/day
Drugs - type and quantity	Dates
Sports played on a regular basis	

Additional Diagnostic Examinations

	No	Yes		No	Yes		No	Yes
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	X-rays	<input type="checkbox"/>	<input type="checkbox"/>	CAT scans	<input type="checkbox"/>	<input type="checkbox"/>
Urine sample	<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound scans	<input type="checkbox"/>	<input type="checkbox"/>	Magnetic resonance	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopies	<input type="checkbox"/>	<input type="checkbox"/>	Biopsies	<input type="checkbox"/>	<input type="checkbox"/>	AIDS test	<input type="checkbox"/>	<input type="checkbox"/>
						Electrocardiograms	<input type="checkbox"/>	<input type="checkbox"/>
						Echocardiograms	<input type="checkbox"/>	<input type="checkbox"/>
						Others	<input type="checkbox"/>	<input type="checkbox"/>

Which one, why and results _____

Medication

Have you ever taken or are under medication for heart diseases or high blood pressure, anticoagulants, insulin, antidepressants, tranquillisers or corticoids? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, which one?
Have you ever undergone: Detoxification <input type="checkbox"/> No <input type="checkbox"/> Yes Chemotherapy <input type="checkbox"/> No <input type="checkbox"/> Yes Radiotherapy <input type="checkbox"/> No <input type="checkbox"/> Yes

Family History

do your parents or siblings suffer from any of the following

	Family relationship	At what age		Family relationship	At what age
Cardiovascular diseases			Psychosis		
Diabetes			Suicide		
Epilepsy			Tuberculosis		
Hypertension			Cancer		

Opinion of the Examining Doctor

Very good

Good

To be postponed

To be denied

In your opinion, which are the candidate's most important pathologies (if any) that might interfere in his/her longevity or future limitation in performing his/her professional and/or personal activities. Specify by order of seriousness.

Place and date _____

Signature of the Doctor _____

Statement

I hereby declare that I have fully and truthfully answered all the questions and know that any incomplete, incorrect or omitted declarations that may induce the Insurer in error, will make this contract null and void, whatever the date on which the Insurer becomes aware of them.

I also declare that I know that any existing physical disability is excluded.

I further declare that I authorise the doctor appointed by the Insurer to contact any doctor or entity who has treated or examined me, requesting any details considered necessary on my state of health to assess the proposed insurance or any claim. Hence, as a result of my permission, I hereby authorise any doctor or entity who has assisted me to provide the doctor appointed by the Insurer with all the information requested even after my death.

Signature of the candidature _____

Reserved for the Insurance Company

Assessment and opinions

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