

**Medical Questionnaire**

**Instructions:**

- Be sure to use the current and correct state specific form.
- **Fees for Incomplete Exams will be charged back.**
- Pose each question exactly as printed.
- Check each 'YES' / 'NO' box - All questions must be answered.
- **Client must be weighed on a scale and measured.**
- Be sure to sign and date the form.
- Include the Agency name and number on all Lab ID slips.
- Paramedicals complete Pgs 1 & 2 and Pg 3 questions 1-11.
- Physicians complete the form in full.
- Non-Med Requirement: Pgs 1 & 2 completed by Agent.
- Deliver or mail the completed form.

This Medical Questionnaire is submitted in conjunction with an application to a Company of the National Life Group:

**National Life Insurance Company**  
**Home / Administrative Office:** One National Life Drive, Montpelier, VT 05604

**Life Insurance Company of the Southwest**  
**Administrative Office:** One National Life Drive, Montpelier, VT 05604  
**Home Office:** 1300 West Mockingbird Lane, Dallas, TX 75247-4921

1. Full Name of Proposed Insured \_\_\_\_\_

2. a. Date of birth \_\_\_\_\_ 2. b. Place of birth \_\_\_\_\_

3. Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Change in last year \_\_\_\_\_ lbs. Reason? \_\_\_\_\_

If any question is answered 'Yes', give dates, details, results & include physician's name, address and phone number in Remarks on page 2.

4. a. To the best of your knowledge, is your health impaired in any way? .....  Yes  No  
 b. Are you taking any medications currently? If so, what and why? .....  Yes  No  
 c. Have you ever applied for or received disability compensation from any source? .....  Yes  No
5. a. Within the past 10 years have you made the decision, or have you been advised by a physician or other medical professional, to reduce alcohol intake or have you attended meetings of an alcohol self-help group or Alcoholics Anonymous? .....  Yes  No  
 b. Except as prescribed by a physician, have you ever used narcotic drugs, amphetamines, cocaine, barbiturates, tranquilizers, hallucinogens or marijuana? .....  Yes  No  
 c. Do you now use nicotine products in any form (including cigarettes, cigars, chewing tobacco, smokeless tobacco, pipe, "the patch", snuff or nicotine gum) or have you used nicotine products in any form within the last 24 months? .....  Yes  No
6. To the best of your knowledge, within the past 10 years, have you been diagnosed with or received professional treatment or advice for:  
 a. Chest pain, heart murmur, rheumatic fever or irregular heart beat? .....  Yes  No  
 b. Habitual cough, asthma, emphysema, sleep apnea, or shortness of breath? .....  Yes  No  
 c. Ulcer, jaundice or chronic indigestion? .....  Yes  No  
 d. Stroke, dizzy spells, epilepsy, convulsions, paralysis, unconsciousness, fainting or memory loss? .....  Yes  No
7. To the best of your knowledge, within the past 10 years, have you received professional treatment or advice for disease or disorder of:  
 a. Heart, veins, arteries, blood, blood pressure, anemia or cholesterol? .....  Yes  No  
 b. Lungs or respiratory tract? .....  Yes  No  
 c. Esophagus, stomach, intestines, rectum, liver or gall bladder? .....  Yes  No  
 d. Kidney, bladder, prostate, genito-urinary organs, pelvic organs or breast? .....  Yes  No  
 e. Eyes, ears, nose, throat or sinuses? .....  Yes  No  
 f. Brain, nervous system or headaches? .....  Yes  No  
 g. Spine, bones, muscles, joints, skin or glands? .....  Yes  No
8. To the best of your knowledge, within the past 10 years, have you been advised by a physician or other medical professional that you had:  
 a. Cancer, polyp or other tumor? .....  Yes  No  
 b. Gout, arthritis, back pain or back disorder? .....  Yes  No  
 c. High blood sugar or diabetes? .....  Yes  No  
 d. Albumin, sugar, protein or blood in the urine? .....  Yes  No  
 e. Renal colic or kidney stone? .....  Yes  No  
 f. Anxiety, depression, neurosis, psychosis, psychological problem or condition? .....  Yes  No
9. Within the past 10 years has a physician or other medical professional diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV) infection? .....  Yes  No
10. Have you had x-rays, electrocardiograms or other diagnostic tests within the past 5 years? If so, where? .....  Yes  No
11. Have you within the past 5 years been in or do you plan to enter or have you been advised by a person licensed in a medical profession, practicing within the scope of his or her license, to enter a hospital for observation, operation or treatment? .....  Yes  No

**Medical Questionnaire (Continued)**

12. Do you have pending, or do you intend to make within the next 30 days, an appointment with any physician or other medical professional? Why? .....  Yes  No
13. Have you consulted any physicians or other medical professionals other than your personal physician within the past 5 years?  Yes  No
14. To the best of your knowledge, has any member of your family been diagnosed with or treated by a member of the medical profession for diabetes, heart disease, cancer, Huntington's Disease or polycystic kidney disease? .....  Yes  No

15. Family History	Age if alive	State of Health	Age at death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Siblings	_____	_____	_____	_____

16. Name and Address of Personal Physician (If none, so state)	Date last seen	Reason consulted & outcome

17. Remarks (Provide dates, details, results & include physician's name, address and phone number to any questions so requested.)

Question Number	Additional Information

**Signatures**

I have read the answers to the foregoing questions. They are correctly recorded and they are complete and true to the best of my knowledge and belief. They shall be used by the Company in any action it takes.

(Please sign name in full)

Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_

Proposed Insured (Print) \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

Witness (Print) \_\_\_\_\_

**Medical Questionnaire (Continued)**

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\_\_\_\_\_ (Proposed Insured) is being examined at the request of \_\_\_\_\_ (Agent)

Explain 'Yes' answers to questions 2-6 in Remarks.

1. Did the Proposed Insured fully understand the questions? (If 'No', provide details in Remarks.)  Yes  No
2. Do you know the Proposed Insured?  Yes  No
3. Are you related to the Proposed Insured?  Yes  No
4. Does the Proposed Insured appear **unhealthy**?  Yes  No
5. Are you the Proposed Insured's personal physician?  Yes  No
6. Do you have any knowledge of the Proposed Insured's habits, environment or other factors which might aid in the appraisal of the Proposed Insured?  Yes  No

**Remarks**

7. Was Proposed Insured weighed and measured?  Yes  No
  - a. Height in shoes: \_\_\_\_\_ ft. \_\_\_\_\_ in.
  - b. Weight in clothes: \_\_\_\_\_ lbs.
8. Girth: (for Males only)  
Chest \_\_\_\_\_ in. Abdomen at umbilicus \_\_\_\_\_ in.
9. Blood Pressure and Pulse
  - a. Three blood pressure readings:  
\_\_\_\_ / \_\_\_\_ , \_\_\_\_ / \_\_\_\_ , \_\_\_\_ / \_\_\_\_  
*Note: If blood pressure is 140/90 or higher, a recheck is required on another day. You may schedule for this now. Please note date of recheck.*
  - b. Pulse rate: \_\_\_\_\_
  - c. Pulse irregularities: \_\_\_\_\_

10. Specimens forwarded to (Name of Laboratory)

\_\_\_\_\_ on (date) \_\_\_\_\_

11. What requirements were completed?

- Blood Profile     Urinalysis     Resting EKG  
 Stress Test     Chest X-Ray

**Questions 12 & 13 to be completed by Physician only**

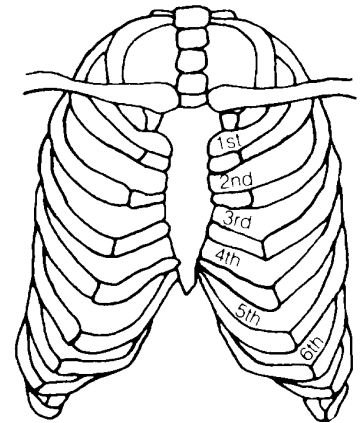
12. Do you find any abnormality of:
  - a. Sight or hearing  Yes  No
  - b. Eyes, ears, nose, or throat  Yes  No
  - c. Lungs or chest  Yes  No
  - d. Abdominal organs or digestive tract  Yes  No
  - e. Nervous system including reflexes  Yes  No
  - f. Thyroid, endocrine system, or skin  Yes  No
  - g. Muscular or skeletal systems  Yes  No
13. Heart - Do you find any:
  - a. Enlargement  Yes  No
  - b. Murmur(s)  Yes  No
  - c. Dyspnea  Yes  No
  - d. Edema  Yes  No

If murmur is present describe and illustrate

Systolic \_\_\_\_\_ Localized \_\_\_\_\_  
 Diastolic \_\_\_\_\_ Soft I-II \_\_\_\_\_  
 Presystolic \_\_\_\_\_ Moderate III-IV \_\_\_\_\_  
 Constant \_\_\_\_\_ Loud V-VI \_\_\_\_\_  
 Transmitted \_\_\_\_\_

Indicate:

- Apex by **X**  
 Murmur area by **○**  
 Heard loudest by **↑**  
 Transmission by **↓**



- Effect of exercise  increase  decrease  none  
 Effect of inspiration  increase  decrease  none  
 Effect of expiration  increase  decrease  none  
 Impression:

Name, Address & Telephone No. of Examining Facility

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

Location/Date & Time of Exam

If exam not arranged by paramed company, Tax ID/EIN # required & please submit a separate "itemized" bill.

Physician/Paramedical (Print)

Signature of Physician/Paramedical