PACIFIC CROSS INSURANCE

More than just insurance. Pacific Cross provides peace of mind.

PHYSICIAN EXAMINATION REPORT

(FOR APPLICANTS OVER AGE 65 ONLY)

to be submitted directly to

Pacific Cross Insurance Company Limited

c/o International Administrators Limited

11/F, O.T.B. Building, 160 Gloucester Road, Wanchai, Hong Kong, SAR

Tel: (852) 2573-2535 Fax: (852) 2573-2917 E-mail: inquiry@pacificcross.com

Note: Please complete in full and submit this form to Pacific Cross. Non-Pacific Cross Pre-Approved Doctors will need to submit board certifications and license information along with this report. The fee shall be refunded to the Policyholder/ Insured Person if the application is approved by the Company but the maximum amount shall not exceed US$250.

PART I (TO BE FILLED OUT BY POLICYHOLDER/ INSURED PERSON

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: _____

Medicare Coverage: YES ☐ NO ☐

This note gives the physician permission to report any medical information requested to Pacific Cross Insurance Co. Ltd. or its administrators.

_____ _____

Signature of Policyholder/ Insured Person Date(MM/DD/YY)

PART II (TO BE FILLED OUT BY PHYSICIAN)

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

	YES	NO
1. Weight loss/weight gain for the past 6 months	☐	☐
2. Unexplained headache/dizziness, seizure, localized weakness or numbness	☐	☐
3. Blurring of vision, recurrent rhinitis, sorethroat, ear discharge or decreased hearing sensation	☐	☐
4. Painful swallowing, recurrent abdominal pain, change in bowel habit and caliber of stool, hematemesis, hematochezia or melena	☐	☐
5. Chest pain, choking sensation, shortness of breath, easy fatigability, orthopnea or paroxysmal nocturnal dyspnea	☐	☐
6. Frequent/painful urination, change in caliber of urine/hematuria, passage of stone	☐	☐
7. Abnormal vaginal discharge or bleeding, painful/abnormal menstruation, breast pain	☐	☐
8. Join pain, non healing wound, change in color of extremities, claudication, cramps, edema	☐	☐
9. Ecchymoses, petechia, easy bruisability, gum or nose bleeding	☐	☐
10. Allergies, history of angioneurotic edema or any anaphylactic reaction	☐	☐

ADDITIONAL INFORMATION: Details: _____

_____

_____

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

FAMILY HISTORY:

_____

_____

_____

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

_____

_____

_____

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

1. VITAL SIGN: BP: (SITTING) _____ (STANDING) _____ HR: _____ /MIN TEMPERATURE : _____ °C
   HEIGHT: _____cm WEIGHT: _____ kg
2. HEENT: EYES _____
   FUNDOSCOPY _____
   NOSE _____NECK/THROAT _____
   EARS _____
3. LUNGS: _____
4. BREAST EXAMINATION (for female): _____
5. HEART: _____
6. ABDOMEN: _____
7. EXTREMITIES: _____

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

A. CHEST X-RAY: _____
B. 12 LEAD ECG: _____
C. ROUTINE URINALYSIS (Micro): _____
D. COMPLETE BLOOD COUNT (CBC): _____
E. LIPID PROFILE: _____
F. LIVER FUNCTION TEST (SGPT, SGOT, GGT, Alkaline phosphate, Bilirubins, Albumin): _____
_____
G. KIDNEY FUNCTION TEST (BUN, Creatinine, Uric Acid): _____
H. THYROID FUNCTION TEST (T3 & T4): _____
I. FASTING BLOOD SUGAR: _____ J. HbAlc: _____
K. HEP TESTS (B & C): _____ L. HIV: _____
M. PSA (MALE): _____ N. PAP SMEAR (FEMALE): _____

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

A. 2-D ECHO CARDIOGRAM WITH DOPPLER: _____
B. TREADMILL STRESS TEST: _____
C. BILATERAL MAMMOGRAPHY ULTRASOUND (for female): _____
D. URINALYSIS (C & S): _____
E. ABDOMINAL ULTRASOUND: _____
F. ALPHA FETO PROTEIN: _____

IMPRESSION:

_____

_____

_____

_____

_____ _____ _____

Signature of Attending Physician | Name of Physician | Date (MM/DD/YY)