

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

ADDITIONAL INFORMATION:

Details: _____

SOCIAL HISTORY

SMOKING

YES NO

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. HbA1c: _____
- 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)