ದಿ ಓರಿಯೆಂಟಲ್ ಇನ್‌ಶ್ಯೂರೆನ್ಸ್ ಕಂಪನಿ ಲಿಮಿಟೆಡ್

दि ओरिएण्टल इंश्योरेन्स कम्पनी लिमिटेड

THE ORIENTAL INSURANCE COMPANY LTD.

Regd. Office: ORIENTAL HOUSE, P.B. No. 7037, A-25/27, ASAF ALI ROAD, NEW DELHI - 110 002

MEDICAL EXAMINATION FOR PRE-INSURANCE HEALTH CHECKUP

TO BE FILLED BY THE PHYSICIAN / DIAGNOSTIC CENTRE

(To be submitted back to under writing office along with the pathology Reports)

A. PERSONAL DETAILS:

1. Name of the Insurer: ______________________________

2. Age: __________ 3. Date of birth ______________________ Sex__________

4. Address: ______________________________

____

Telephone No.: ______________ E-mail ID: ______________________

Identification Document Details: ______________________________

B. PHYSICAL EXAMINATION: *(Only to be filled by doctor)*

MEASUREMENTS AND WEIGHTS:

Height : __________ cms Weight: __________ Kg BMI: __________

Abdominal girth: __________ cms Chest measurement: Inspiration : __________ cms

Expiration: __________ cms

PULSE: Rate _______ Per Minute Rhythm: __________ Condition of vessel: __________

Dorsal Pedis: _______ Per Minute Post.Tibial: __________ Per Minute

BLOOD PRESSURE: __________ mmHg

BP PATIENT SITTING: __________ mmHg

BP PATIENT LYING: __________ mmHg

BP DIFFERENCE LYING /SITTING: __________ mmHg

Skin:

Chronic Ulcer: Yes / No details __________

Swelling: Yes / No details __________

Skin Discoloration: Yes / No details __________

Eczema: Yes / No details __________

Varicose Veins: Yes / No details __________

OPHTHALMIC EXAMINATION:

Slit Lamp exam for Cantaract	Right Eye	Left Eye	I.O.P Glaucoma	Right Eye	Left Eye

Fundus Examination: For Maculopathy / Retinopathy etc. ______________________________

Grade 1__________

Grade-2__________

Grade-3__________

Grade-4__________

Visual Acuity and best corrected vision: RE: LE:

CARDIOVASCULAR SYSTEM:

1. Is the heart normal in size and position? ____________________
2. Are the heart sounds normal? If no. is there a gallop/murmur/click? Also please given the rate, point of maximum intensity and conduction-____________________
3. History of palpitation and /or heaviness in chest
____
4. Taking any Medication for Hypertension? Give name and dosage and since when?
____
5. Taking any Medication for Diabetes Mellitus? Give name and dosage and since when?
____
6. Diabetes Mellitus of Type-1 or Type -2
____

GENITO-URINARY SYSTEM:

1. Is there any evidence of past or present Genito-Urinary system disease?
____
2. STD, Is the client or the spouse advised for any treatment for any Veneral disease/STD?
____
3. Any history of urgency, dribbling, obstruction while urination?
____
4. History of stones, passing blood in urine?
____

RESPIRATORY SYSTEM:

1. Is the chest symmetrical?
____
2. Are there any symptoms or signs suggesting abnormality or disease of respiratory system?
____
3. History or any sign or symptoms of asthma?
____
4. Any Rales, Ronchi, wheezing or any other finding?
____
5. Snoring / Sleep Apnoca Syndrone ?

G.I.T SYSTEM:

Oropharyngeal:

1. Are the gums, teeth and tongue healthy? Give details
____
2. Is there any evidence of past or present disease of oropharynx ? Give details
____

Abdomen:

1. Is there any evidence of enlargement of liver or spleen? Give details
____
2. Is there any lump or tenderness or free fluid, or any abnormality in the abdomen or pelvic region?
____
3. Any symptoms of passing frank blood in stool or malena ?
____
4. Evidence of, if yes, please describe

   Hernia:____________________

   Hydrocele:____________________

   Fissure:____________________

   Fistula: ____________________

   Piles:____________________

Acidity / Gastro esophageal refluxes:

Any other details____

NERVOUS SYSTEM:

Is there any evidence of nervous disease such as paralysis, epilepsy, wasting, tremor, involuntary movements, diplopia, migraine etc.?

____

____

Knee jerks (Rt)________(Lt)__________ details______________________

Pupil reflexes (Rt)________(Lt)__________ details______________________

SKELETAL SYSTEM:

1. Is there any evidence of past or present disease of joints like arthritis,etc?

   ____

2. Any evidence of spinal defect/deformity/disc pathology/spondylosis?

   ____

3. Knee Joint Examination

   Swelling (Rt) ________ (Lt) __________

   Vargus &/or valgus deformity (Rt) ________ (Lt) __________

   Locking (Rt) ________ (Lt) __________

   Clicking (Rt)________ (Lt)__________

   Poplitial fossa deformity/swelling (Rt) ________ (Lt) __________

   Details of the above mentioned positive findings and /or any other positive findings

   ____

   ____

4. SLR test active (Rt)________(Lt)__________

   Details of positive SLR:______________________

5. Tenderness over spine? Give details

   ____

ENT:

1. Is there any evidence of past or present diseases of ear, nose & Throat, Chronic Tonsillitis?

   ____

2. Deviation of nasal septum and /or sinusitis? Give details

   ____

3. Any evidence of decreased hearing? Give details

   ____

FOR FEMALE APPLICANTS ONLY:

1. Is there any disease of breast, lump, swelling? ______________________
2. (I) Is there any evidence of pregnancy? ______________________

   (II) If Pregnant, are any complications to be expected? ______________________

   Do you suspect any disease of uterus, cervix of ovaries? ______________________
3. Is there any weakness or injury resulting from child bearing or miscarriage?

   ____
4. Post obstetric History

   a. LSCS

b. Incisional Hernia

c. Urinary In continuance

5. Any menstrual complaints (irregular cycles / Dysmenorrhoea / PCOD?

FINDINGS OF TEST REPORTS :

1. Glycocylated Haemoglobin : ____________________
2. Urine albumin urea:
3. Eye Check-up : ____________________
4. Whole abdomen and pelvic Sonography : ____________________
5. ECG : ____________________
6. TMT : ____________________
7. X-RAY KNEE : ____________________

GIVE DETAILS OF FAMILY HISTORY:

Family History of hypertension (BP) ____________________

Family History of Heart Disease____________________

Family History of Diabetes Mellitus (DM)____________________

Diabetes Type-1 or Type-2____________________ ____________

Family History of Cancer____________________

Family History of Thalasemia/any blood disorder____________________

Family History of asthma ____________________

For females, Family History of Breast Cancer____________________

Any other details of family history:____________________

HABITS:

Alcohol: Yes/ No, regular / occasional / social ,since when ________yrs, Quantity ________/day.

Smoking: Yes/ No, regular/occasional / social, since when _______yrs, Quantity ________/day.

If stopped since when: ____________

Any Other ____________________

RECOMMENDATION / OBSERVATION OF THE DOCTOR:

a) Have you observed any variation from the SELF-DECLARATION FORM AND TEST REPORT. If yes, give details:

____

b) Any Specific Finding upon medical examination indicating whether any disease/ailment is to be excluded from the scope of the policy.: (Please Specify)

____

____

____

I confirm that I have examined the client after verification of his /her identify and the findings stated above are true and correct to the best of my knowledge.

Date: ____________ Place: ____________

____________________ ____________________

Name of the Medical Examiner Signature of Medical Examiner

FOR OFFICE USE ONLY

Underwriter Comments/Recommendations: ____________________

____

____

____

Dispatched to ____________ on ____________ Approved by ____________________

Signature & Date ____________________

V.P. 50,000 Nos - 9/06