Allianz AYUDHYA

MEDICAL EXAMINER'S CONFIDENTIAL REPORT FOR ADULT/PAYER/JUVENILE

A Examination of Adult Policy/Payer Benefit Policy

Policy No. | | | | | | | | | | |

Name of Insured/Payer ID Card No. .... ☐ male ☐ female	Height	Weight	Chest (Force inspiratory)	Chest (Force expiratory)	Abdominal (At Umbilicus)

BLOOD PRESSURE *(If over 140 systolic or 90 diastolic record 3 readings)*

Systolic			
Diastolic 5th phase			

Pulse	At Rest	After Exercise	3 Minutes Later
Rate Per Minute			
Irregularities Per Minute			

Exercise only irregular pulse, heart murmur or BP over 150/100

	Yes / No	DETAILS of "YES" answer. (Identify Item)
1. a) Are you personally or professionally acquainted with the applicant? If so, how long?	☐ ☐	.....
b) Is appearance unhealthy or mentally health or older than stated age?	☐ ☐	.....
c) Is there any reason to suspect intemperate habits?	☐ ☐	.....
d) Are there any identification marks (such as scars, birthmarks ect.)?	☐ ☐	.....
2. Do you find any evidence of past or present disease or abnormality? Of.-		
a) Central or peripheral nervous system (including reflexes, gait, paralysis)?	☐ ☐	.....
b) Respiratory system (lungs, pleura, chest wall?	☐ ☐	.....
c) Abdomen (including stomach, liver, spleen, hernias)?	☐ ☐	.....
d) Genito-urinary system	☐ ☐	.....
e) Thyroid or other endocrine glands or metabolic and haemopoietic system)?	☐ ☐	.....
f) Eyes, ear nose, throat and mouth (including-impairment of sight or hearing)	☐ ☐	.....
g) Skin, bones or joints (including varicose veins deformities, lameness, amputations)?	☐ ☐	.....
3. HEART : Apex Beat located at.....intercostal space.....inches to the left of MIDCLAVICULAR line. Is there any		
a) Arteriosclerosis or aneurysm?	☐ ☐	.....
b) Hypertrophy or edema?	☐ ☐	.....
c) Murmur - (If murmur is present describe below)?	☐ ☐	.....
Location: ☐ apex ☐ base - over.....area		
Timing: ☐ systolic ☐ diastolic ☐ presystolic		
Intensity: ☐ soft ☐ moderate ☐ loud		
Transmission: ☐ none ☐ axilla ☐ scapula		
After exercise: ☐ absent ☐ decrease ☐ unchange ☐ increase		
Diagnosis.....		
Do you suspect any abnormality in the heart or vascular system?		

4. URINALYSIS	pH	Specific gravity	Albumin	Blood	Sugar

Send for microscope urinalysis if:
a) Blood pressure is over 140/90
b) Albumin or blood sugar is present.
c) There are any finding or history of urinary disease.
d) Applicant is a diabetic or high blood pressure.

5. a) Are you aware of any unfavourable features which affect his/her longevity		
(i) from the personal or family history?	☐ ☐	.....
(ii) disclosed by your medical examination?	☐ ☐	.....
b) Do you recommend any additional test or reports?	☐ ☐	.....

ลายมือชื่อ .....ผู้เอาประกันภัย/ผู้ชำระเบี้ยประกันภัย

(.....)

I here by certify that I have carefully made this examination at.....
.....
On.....(date), at.....(time)
Signature .....MD.
Medical Practitioner Registration No.....

B Examination of Child (strip child to waist) To be used only in case children under age of 20 years

Name of child ☐ Male ☐ Female

ID Card No. | | | | | | | | | | | | | |

Height .....cms

Weight .....kgs

	Yes / No	Details of "YES" answers. (Identify Item)
1. **A**–Has the child any impairment of physical growth or mental development or peculiar look?	☐ ☐	.....
B–Has the child any impairment of sight or hearing?	☐ ☐	.....
C–Has the child any deformity or lameness?	☐ ☐	.....
D–Has the child been hospitalized? When? Where? Why?	☐ ☐	.....
2. After careful inquiry and examination, do you find any evidence of part or present illness of:		
A–Brain or Nervous system? Convulsions?	☐ ☐	.....
B–Heart or lungs?	☐ ☐	.....
C–Abdomen, kidneys or urinary tract?	☐ ☐	.....
D–Bones, joints or muscles?	☐ ☐	.....
E–Eyes, ears, nose, throat, skin glands or other part of the body?	☐ ☐	.....
F–Endocrine or other disease	☐ ☐	.....
3. Are you satisfied as to Child's identity?	☐ ☐	
4. Is the child normal and healthy in your opinion? (Any weight change in the past 6 months?	☐ ☐	
5. **Urinalysis** (Age over 5 yrs) Albumin.....Blood.....Sugar.....		

Additional remarks: (State anything discovered by you, not fully set forth above, which may influence the risk)

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ข้าพเจ้าในฐานะผู้ปกครอง/ผู้ชำระเบี้ยประกันขอรับรองว่า
ได้นำผู้เยาว์ข้างต้นนี้มารับการตรวจจากแพทย์จริง

ลายมือชื่อ .....ผู้ปกครอง/ผู้ชำระเบี้ยประกันภัย

(.....)

I here by cartify that I have carefully made this examination at

.....

On.....(date), at.....(time)

Signature .....MD.

Medical Practitioner Registration No.....