MEDICAL EXAMINATION FORM

Swiss life insurance companies

ASA | SVV

Schweizerischer Versicherungsverband
Association Suisse d'Assurances
Associazione Svizzera d'Assicurazioni
Swiss Insurance Association

Please note

- We ask **the physician** to go through these questions together with the applicant and fill in the answers himself / herself if possible.
- Please use **block letters and write legibly**. Thank you.
- Insurers are prohibited by law from requesting the results of antenatal or **presymptomatic genetic tests** (testing to see whether a person is predisposed to illness before symptoms appear) unless certain conditions are met. If the preconditions for the right to ask questions are met, the investigation shall be carried out by using a separate form. Therefore, such findings do not have to be specified in the present questionnaire. Results which are voluntarily submitted may not be used by the insurers. **Genetic examinations for diagnostic purposes**, i. e. to clarify symptoms of illness which have already occurred, are not affected by this legal provision and must be declared.

Select insurance...

GLN

Policy- / application no.

Applicant's personal details

Surname | Firstname | Date of birth | Description of the current occupation

Address | Postcode | City | Country

Medical history

No.	Questions	No	Yes	If yes, please explain in detail (for all questions)
01	Do you exercise or practise sport regularly?	◯	◯	Which? How often?
02	Have you consumed or smoked tobaccos or nicotine in any other form in the past 3 years?	◯	◯	☐ Cigarettes ☐ E-Cigarettes ☐ Cigars ☐ Pipe ☐ Something else (e. g. water pipe, chewing tobacco, nicotine patch) What? Daily amount? When was the last time?
03	Do you drink alcohol?	◯	◯	Which drinks? How much? How often?
04	Are you or have you been, in the last 10 years, in consultation or treatment in connection with your consumption of alcohol (incl. special clarifications / examinations / advising centre)?	◯	◯	When? By whom? Name and address
05	Do you take drugs or have you taken any in the past 10 years?	◯	◯	Which? How often? How long? When was the last time?
06	Do you take medication regularly or repeatedly or have you done so in the past 5 years or have been described medications in the same period?	◯	◯	Which? How often? Why? From when to when?
07 a.	Have you ever been hospitalised?	◯	◯	Why? When?
b.	Did you undergo endoscopies of the joints or body cavities, catheter examinations or other surgical procedures?	◯	◯	Why? When?
c.	Do you currently present any illnesses / health conditions / consequences of accidents?	◯	◯	Which?
d.	Is your ability to work or gain income limited in any way?	◯	◯	Why? Since when? Degree / Extent?
e.	Have you been completely or partially unable to work without interruption for more than 4 weeks during the last 5 years?	◯	◯	Why? From when to when?
f.	Did you ever apply for any medical, educational, professional or other measures at an insurance?	◯	◯	Which insurance? When? Why?
08	Have your parents, siblings or grandparents had any diseases of the nervous system, cardiac diseases, strokes, diabetes, cancer or hereditary diseases before the age of 55?	◯	◯	Wich disease(s)? How many persons?

Date and signature of the applicant

Date | Signature

No.	Questions	No	Yes	If yes, please explain in detail (for all questions)		
09	**Do you or did you have, in the last 10 years, any diseases, disorders or problems connected with**			Which?	When? Duration? Cured?	Physicians / other therapists with addresses:
a.	the **respiratory organs**, such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other problems?	○	○			
b.	the **heart** or **vascular system**, such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, cardiac dysrhythmia, stroke, phlebitis, varicose veins or other problems?	○	○			
c.	the **digestive system**, such as hiatus hernia, gastric or intestinal ulcer / inflammations / haemorrhages, haemorrhoids, jaundice, diseases of the liver, gall bladder, pancreas or other problems?	○	○			
d.	the **urinary tract** or **sexual organs**, such as diseases of the kidneys, ureters, bladder, prostate or testicles, uterus or ovary diseases, illnesses of the female breast, kidney / bladder stones, blood or protein in the urine or other problems?	○	○			
e.	the **nervous system**, such as epilepsy, dizziness, headache, paralysis, neuritis or other problems?	○	○			
f.	the **mental state**, i. e. mental disorders such as depression, anxiety, stress, eating or psychosomatic disorders, burnout or other problems?	○	○			
g.	the **musculoskeletal system** (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons), such as disorders of the back, neck or shoulders, arthrosis, rheumatism or other problems?	○	○			
h.	the **eyes**, such as decreased visual acuity or refraction power, cataract (lens opacity) or glaucoma, retinal disease or other disorders?	○	○	Diopters: left /right		
i.	the **ear**, such as hearing difficulties, inflammation, tinnitus or other disorders?	○	○			
j.	the **metabolism** or **blood**, such as diabetes mellitus, elevated cholesterol, gout, hormonal disturbances (thyroid gland, adrenal glands), anaemia, coagulation disturbances or other disorders?	○	○			
k.	the **immune system** or infectious diseases, such as HIV infection, sexually transmitted diseases, hepatitis, Lyme disease, tropical diseases or other disorders?	○	○			
l.	due to **skin disorders** or **allergies**, e.g. to foods, pollen, animal hair or others?	○	○			
m.	due to **tumour diseases** (benign or malignant)?	○	○			
n.	due to **deformities** or **congenital defects**?	○	○			
o.	due to consumption of or **dependence** on medications, alcohol, drugs or other addictive substances?	○	○			
p.	other illnesses, disorders or problems not listed above?	○	○			
10	Have you ever attempted suicide?	○	○			
11	Are there medical consultations or treatments, a hospital stay or any surgery currently planned or recommended?	○	○	Why?		
12	Have you consulted any physicians, chiropractors, osteopaths, physiotherapists, psychotherapists or other medical experts in the **last 5 years** that have not already been mentioned?	○	○	Names and exact addresses		
				Why?	When?	Cured?
13	Which physician did you last consult?		⇨	Names and exact addresses		
			⇨	Why?	When?	Results?
14	Which physician is most familiar with your medical history?		⇨	Names and exact addresses		

I hereby declare that I have answered the above questions 1 to 14 honestly and completely. The validity of the contract depends on the questions being answered correctly and completely. I authorise any doctors, medical institutions and insurance bodies approached by the company to provide any information necessary for consideration of the application.

Place	Date	Signature of the applicant

I hereby confirm that I have handled each question above together with the applicant.

Place	Date	Signature of the physician

Medical evaluation of case history:

Medical examination including urinalysis

Please indicate and detail all pathological or abnormal findings. Thank you.

No.	Questions	No	Yes	If yes, please explain in detail (for all questions)
15 a.	**Date** of medical examination:	⇨		
b.	Do you personally know the person to be insured?	◯	◯	Personally known since:
				Identity checked on the basis of: ◯ Passport ◯ ID ◯ Driving licence ◯ Residence permit
c.	Have you yourself previously examined or treated the applicant?	◯	◯	When?
				Why?
				Results?
16	**Height** (without shoes) / **Weight** (without clothes)	⇨		cm kg
17	**Skin** Are there any signs of skin disease or scars?	◯	◯	
18	**Respiratory Organs**			
a.	Are the results of percussion and auscultation abnormal?	◯	◯	Cause?
b.	Are there any signs of disease of the respiratory organs?	◯	◯	
19	**Heart and Circulation**			
a.	Is there a heart murmur?	◯	◯	If yes: ◯ systolic ◯ diastolic
	Point of maximum intensity and transmission?	⇨		
	Is the heart murmur pathological?	◯	◯	
b.	Are there audible carotid murmurs?	◯	◯	
c.	Pulse rate, blood pressure	⇨		Beats per minute
		⇨		Blood pressure in mmHg: systolic / diastolic
	Please repeat measurement if the result is over 135 / 85 mmHg	⇨		Blood pressure, 2nd reading: /
d.	Pulse rhythm	⇨		◯ regular ◯ irregular
e.	Are there audible vascular sounds?	◯	◯	Where?
f.	Is pulsation of the pedal arteries absent or diminished?	◯	◯	
g.	Are there any signs of insufficiency or decompensation (shortness of breath, cyanosis)?	◯	◯	
h.	Are there any varicose veins or signs of chronic venous insufficiency?	◯	◯	

Date and signature of the physician

Date

Signature

No.	Questions	No	Yes	If yes, please explain in detail (for all questions)
20	**Digestive Organs and Abdomen**			
a.	Are there any abnormalities of the teeth, tongue, tonsils, mucous membrane or throat?	◯	◯	
b.	Are there any abnormalities on examination, palpation, percussion and auscultation of the abdomen?	◯	◯	
c.	Is there a hernia?	◯	◯	
21	**Urinary Tract and Sexual Organs**			
a.	For **male** applicants: Is there any suspicion of disease of the urinary tract or sexual organs?	◯	◯	
b.	For **female** applicants: Is there any suspicion of disease of the urinary tract or sexual organs, pathological breast abnormalities or is the applicant pregnant?	◯	◯	
22	**Nervous System / Sense Organs**			
a.	Are there any signs of disease of the sense organs, particularly diminished sight or hearing?	◯	◯	
b.	Are there any indications of neurological diseases, disorders or insufficiencies e. g. motor function, reflexes, sensitivity, balance?	◯	◯	
23	**Psyche** Are there any recognisable psychological or mental abnormalities (e. g. inappropriate moodiness or abnormal behaviour) or are there indications that there are currently stressful situations or conflicts?	◯	◯	
24	**Musculoskeletal System** Are there signs of spinal disease or deformations or any other diseases of the musculoskeletal system?	◯	◯	
25	**Other**			
a.	Are there any enlarged lymph nodes?	◯	◯	Where?
b.	Are there any indications of endocrinological disorders?	◯	◯	
c.	Is there any suspicion of eating disorders, alcohol abuse or drug use?	◯	◯	
d.	Were there any other findings that could increase the risk level?	◯	◯	
26	**Urinanalysis (urine test strip)**			
	Urine contains protein?	◯	◯	
	Urine contains sugar?	◯	◯	
	Urine contains erythrocytes?	◯	◯	
	Urine contains leukocytes?	◯	◯	
	Urine contains something else?	◯	◯	
	IIf the results from the urine test strip show abnormalities, please provide **urinary sediment** and quantitative data	⇨		Ec Lc Other

hereby confirm that I have questioned and examined the applicant and have answered the above questions 15 to 26 to the best of my knowledge and in good faith.

Place	Date	Signature of the physician

Comments:
(further conclusions, e. g. risk factors, suggestions for examinations and / or therapy)

Please enclose copies of available examination findings. Thank you

Physician's address

Phone
Fax
GLN
ZSR
eMail

Firma _____
when sent electronic obsolete

Date

Electronic transmission

«Invio diretto» è disattivato perché il destinatario non può essere indirizzato in modo sicuro (HIN-Mail|Medidata)!