FULL MEDICAL EXAMINATION FORM
FOR APPLICATION OF REACTIVATION OF PLAN MEMBERSHIP

Part I- MEDICAL QUESTIONNAIRE

INSTRUCTIONS - Every question must be asked the Member by the Medical Examiner and answers must be recorded in ink in the Examiner's own handwriting. Examination must be done in private and the Member must sign in the presence of the Examiner.

MEMBER'S NAME Last First M.I.	**SEX**	**Month Day Year** BIRTHDATE: BIRTH PLACE:

	YES	NO
1. Have you ever been treated for or ever had any known indication of		
a. Disorder of eyes, ears, nose or throat?	a. ☐	☐
b. Dizziness, fainting,convulsion, headache, speech defect, paralysis, or stroke; mental or nervous disorder?	b. ☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood-spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	c. ☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	d. ☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach intestines, liver or gall bladder?	e. ☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	f. ☐	☐
g. Diabetes, thyroid orother endocrine disorders?	g. ☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout,or disorder of the muscles or bones, spine, back or joints?	h. ☐	☐
i. Deformity, lameness or amputation?	i. ☐	☐
j. Disorder of skin, lymph glands, cysts, tumor or cancer?	j. ☐	☐
k. Allergies, anemia or other disorder of the blood?	k. ☐	☐
l. Excessive use of alcohol, or any habit-forming drug?	l. ☐	☐
2. Are you now under observation or taking treatment?	☐	☐
3. Are you a cigarette smoker? If so, how many packs do you smoke daily? one or more _____ less than one _____	☐	☐
4. Other than above, have you:		
a. had any physical disorder or any known indication therof?	☐	☐
b. had a medical examination, consultation, illness, injury, surgery?	☐	☐
c. been a patient in a hospital, clinic, institution, or medical facility?	☐	☐
d. had elctrocardiogram, X-ray, other diagnosis tests?	☐	☐
e. been advised to take any diagnostic test, hospitalization, or surgery, which was not completed	☐	☐
5. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
6. Have you ever applied for or received a pension payment, or benefit due to injury, sickness or disability?	☐	☐
7. Have you a parent, brother, or sister who died of or had high blood pressure, tuberculosis, diabetes, cancer, heart, kidney disease, or mental illness? If so, at what age? _____	☐	☐
8. In the last ten years have you:		
a. Had or been told you have Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or AIDS related conditions?	☐	☐
b. Tested positive for anti-bodies to the AIDS (Human T-Cell Lymphotropic Type III or HIV) virus?	☐	☐
c. Received any blood transfusion?	☐	☐
9. Questionnaire for Females only:		
a. Have you any abnormal menstruation, pregnancy, childbirth or disorder of the female organs or breasts?	☐	☐
b. Are you pregnant? If yes, how many months? _____	☐	☐
c. Date of last delivery or last menstrual period? _____	☐	☐

Details of "YES" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICATION ITEMS. Include diagnosis, result, dates, duration and names and addresses of all attending physicians and medical facilities).

I hereby agree that the foregoing questions and answers shall form part of my pending application for reactivation/ reinstatement of my

I hereby agree that the foregoing questions and answers shall form part of my pending application for reactivation/ reinstatement of my lapsed membership, the approval of which will depend on its evaluation.

Signed at _____ on _____

Signature of Medical Examiner _____

Signature of Member_____

Member's Right Thumbmark (if unable to sign)

Part II MEDICAL EXAMINER'S REPORT

INSTRUCTION: In performing the examination, bear in mind history in Part I submitted in connection with Reinstatement

1. a. Name and address of Member _____
(*If none, so state)*

b. Date and reason last consulted _____

c. What treatment was given or medication prescribed? _____

2. HEIGHT meter Ft. In.	WEIGHT kilos lbs.	CHEST (full inspiration) in.	CHEST (forced expiration) in.	ABDOMEN at Umbilicus in.

Did you weigh and measure Member? ☐ Yes ☐ No

3. BLOOD PRESSURE (*if above 140 systolic or 90 diastolic, report additional readings at 5-minute interval)*

	1st	2nd	3rd
Systolic			
Diastolic (Disappearance of sound)			

4. PULSE *(If irregular or rate is over 90 or less than 60 per minute, perform EXERCISE TEST*)*

	At rest	After Exercise	3 Minutes Later
Rate per minute			
Irregularities per minute			

* Ten full kneebends from standing position in one minute.

5. HEART is there any

a. Enlargement? _____ c. Arrhythmis? _____

b. Murmur? _____ d. Dsynea? _____

(Give details and your impression at space provided).

6. Is there, on examination, any abnormality of the following:
(*please encircle applicable items and give details)*

	YES	NO
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b. Skin (incl. scars), lymphnodes, varicose veins or peripheral arteries?	☐	☐
c. Nervous System (include reflexes, gait, paralysis?)	☐	☐
d. Respiratory System?	☐	☐
e. Abdomen (include scars)?	☐	☐
f. Endocrine System (include thyroid and breasts)?	☐	☐
g. Musculoskeletal System (include spine,joints, amputations, deformities)?	☐	☐
7. Is appearance unhealthy or older than age stated?	☐	☐
8. Are you aware of additional information about the health habits that may affect the risk adversely?	☐	☐
9. Are you related to the Member?	☐	☐

(A CONFIDENTIAL REPORT MAY BE SENT TO THE MEMBERSHIP DIVISION PPSTA)

10. How long have you known the Member?

If yes, please give details:

I certify that I have carefully examined the person named above and that the examination was made at _____ _____ on _____ at _____ o'clock AM/PM. I have asked each question exactly as set forth in Part I ar that the Member's answers thereto are in my handwriting and are exactly as stated by the Member to me and that the Member signed the declarations at the foot of Part I in my presenc

_____
Signature of Examiner

_____
Examiner's Name in Print

_____
PTR License No.

_____

Affiliated Hospitals and/or Clinics

INSTRUCTION TO THE MEDICAL EXAMINER

1. When an examination has begun, the report thereof becomes the property of PPSTAand must not be suppressed nor destroyed regardless of your recommendation in order to avoid declination.
2. Your report should give the PPSTA a clear picture of the person examined.
3. An examiner is not allowed to examine his relatives.
4. Any erasures or alterations in the statement made by the Member must be initialed by him. Any erasures or alterations in your report should be, initialed by you.
5. Please review both sides of the form mailing to see that every applicable question is fully and correctly answered.