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FULL MEDICAL EXAMINATION REPORT

Statement to the Medical Examiner

APPLICANT'S DETAIL PRIVATE & CONFIDENTIAL

NOTE:
You are required to disclose in this proposal form fully and faithfully all the relevant facts which you know or ought to know, otherwise the certificate issued pursuant to this proposal form may be voided.

Name of Agent and code No.: _____ Certificate No.: | | | | | | | | | | | | |

A. PERSONAL DETAILS

1. Name of Applicant (Capital Letters)

2. NRIC No. | | | | | | | | | | | | |

3. Date of Birth | | | | | | | | |
Day Month Year

4. Age | | | |
Year Month

5. Sex | | Male | | Female |

6. Occupation (including part-time)
_____

7. Amount Covered
RM | | | | | | | | |

8. Name & address of your personal Doctor that you frequent most:
_____

9. Date last consulted Doctor and reasons:
_____

10. At present are you on any form of medication? ☐ Yes ☐ No (if yes, please state reason and type of medication)
_____

11. Have you at any time consulted a Psychiatrist? ☐ Yes ☐ No (if yes, please give details and date):
_____

B. HEALTH DETAILS			DETAILS of "Yes" answers.
1.	Have you EVER had or been told you had or been treated for		*Kindly include diagnosis, dates, results, duration, names and address (s) of all attending doctors and medical facilities.*
	a. Epilepsy, fainting spells, seizure, nervous or mental condition, neuritis paralysis or any disease or abnormality of the brain or nervous system?	☐ Yes ☐ No	
	b. Giddiness, loss of consciousness, breathlessness, chest pain, high blood pressure, palpitation or any disease of the heart, blood or blood vessel?	☐ Yes ☐ No	
	c. Blood spitting, tuberculosis, asthma, habitual cough, pleurisy or any respiratory or lung disease?	☐ Yes ☐ No	
	d. Recurrent indigestion, ulcer, hernia or disease of liver, gall bladder, stomach or intestine?	☐ Yes ☐ No	
	e. Urinary sugar/albumin/stones, venereal disease, menstrual disorder or diseases of the kidney, prostate, urinary or genital system?	☐ Yes ☐ No	
	f. Diabetes, goiter any disease or abnormality of the thyroid or other endocrine glands?	☐ Yes ☐ No	
	g. Diseases of eyes, ears, nose (including nose bleeds) or throat?	☐ Yes ☐ No	
	h. Cancer, tumor, cyst or any growth?	☐ Yes ☐ No	
	i. Jaundice, hepatitis or any disease of the liver or a hepatitis carrier?	☐ Yes ☐ No	
	j. Malaria, dysentery or any tropical diseases?	☐ Yes ☐ No	
	k. Rheumatic fever, arthritis, gout or any disease of the spine (inclusive of prolapsed intervertebral disc), bone, joint, muscle, connective tissue, lymph nodes or any diseases of the skin?	☐ Yes ☐ No	
2.	Have you ever: Received any medical advice, counseling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related condition or been told you had any of these or have you had any HIV testing done (please state results), OR in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhea, enlarged lymph nodes or unusual skin lesions?	☐ Yes ☐ No	

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B. HEALTH DETAILS (Cont.)			**DETAILS of "Yes" answers.**
3.	In the PAST 5 YEARS, have you had any: a. Diagnostic tests such as x-ray, mammogram, electrocardiogram, CT scanning, echo or ultra sonogram, blood or urine studies? b. Illness, injury operation, medical advice, hospital treatment or any physical check-up not mentioned above?	☐ Yes ☐ No ☐ Yes ☐ No	*Kindly include diagnosis dates, results, duration, names and address of all attending doctors and medical facilities*
4.	a. Do you smoke cigarettes, pipes, cigars etc? If so, in what quantity and duration? b. Do you drink beer, wine or spirits? If so, in what form and quantity? c. Have you ever used habit forming drugs or narcotics, or been treated for alcoholism or drug habit? d. Do you have any other physical defects or health impairments?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
5.	a. To the best of your knowledge and belief, has any of your immediate family ever had or died from asthma, tuberculosis, diabetes, heart disease, hypertension, mental disease, kidney disease or any other hereditary disease? b. Has your spouse ever suffered from any AIDS related condition or been tested HIV positive?	☐ Yes ☐ No ☐ Yes ☐ No	
	c.		
6.	a. Has your weight changed more than 5 kg in the past years? If so, why? b. Has any application for coverage on your life ever been declined, withdrawn, postponed, rated, reinstated or modified in any way?	☐ Yes ☐ No ☐ Yes ☐ No	
7.	**FEMALE Only** a. Have you ever had any disease of the breast or female organs or complications during childbirth? b. Are you now pregnant? If Yes, how many months? _____ Months	☐ Yes ☐ No	

Family Record	Age if Living	Cause of Death	Age of Death
Father			
Mother			

C. DECLARATION AND CONSENT

I confirm that the above answers given by me are full, complete and true and agree that they form part of any certificate, where these answers are, or may be relied upon by the Company

I having read and understood the contents here of, hereby authorize FWD Takaful Berhad., any of its appointed medical examiners or designated laboratories to conduct or perform blood and/or urine tests as may be necessary to underwrite my application for takaful coverage. These may include, but are not limited to, tests for cholesterol and related blood test, diabetes, liver or kidney disorders, infection by AIDS virus, immune disorders or the presence of medication, drugs, nicotine or their metabolites.

Provided that, unless my prior consent has been obtained, FWD Takaful Berhad shall at all times, keep all results of any such tests confidential & use there of shall only be for the purpose of my application or further application for takaful coverage with FWD Takaful Berhad except to such an extent that disclosure is required by any proper Government Authority or by Law.

_____ _____

Signature of Applicant

Date:

Witnessed by (Medical Examiner)

Name:
NRIC No:
Date:

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Medical Examiner's Confidential Report (To be Completed by Medical Examiner)

MEDICAL REPORT PRIVATE & CONFIDENTIAL

IMPORTANT NOTE: This examination should be made in private; no third person should be present.

D. PHYSICAL EXAMINATION

1. Height	2. Weight	3. Chest *(force expiration)*	4. Chest *(force inspiration)*	5. Abdomen *(at umbilicus)*
cm	kg	cm	cm	cm

Visual acuity	6. Right eye	7. Left eye	8. Funduscopy
Uncorrected			
Corrected			

E. HEALTH			**DETAILS of "Yes" answers.**
1.	Have you ever seen the applicant professionally before? If yes, we would appreciate if you would review your records to confirm that all items of the applicant's physical history have been declared overleaf. If not, please give details of any omissions or inaccuracies.	☐ Yes ☐ No	*If any answer is "Yes", kindly provide full details of adverse findings and opinions*
2.	Are you in any way related to the applicant or to the agent?	☐ Yes ☐ No	
3.	a. Is there any evidence of ulcers, hernia, piles, fistula or varicose veins? b. Does appearance indicate poor health? c. Does he/she appear older than stated age? d. Is there any reason to suspect intemperate habit?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
4.	Do you find any evidence of past or present disease or abnormality of: a. Respiratory system (lungs, own chest wall)? b. Central or peripheral nervous system (including reflexes, gait, paralysis)? c. Genito – urinary system? d. Gastrointestinal system (including hernias)? e. Breasts, skim bones or joints (including varicose veins, deformities, lameness, amputation, scars / identifying marks)? f. Eyes, ears, nose, throat and mouth (including impairment of sight or hearing)? g. Thyroid or other endocrine glands or metabolic and hemopoietic systems? h. Lymphatic system?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
5.	**Urinalysis** (N.B.: "Trace" amount must be noted) — Blood	Sugar	Albumin	Specific Gravity in units Send specimen for microscopic urinalysis if: i. Blood pressure is over 140/90 ii. Albumin, blood or sugar is present iii. Family history of diabetes iv. There are any findings or history of urinary disease v. Applicant is a diabetic or under treatment for blood pressure **For female applicant, to indicate LMP when blood is present** Is blood specimen sent for analysis? YES / NO If yes, which profile? _____	
6.	**Blood Pressure** *(If over 140 systolic or 90 diastolic or with history of hypertension record 3 readings at an interval of 5 minutes).*			

Systolic	mmHg	mmHg	mmHg
Diastolic (5th phase)	mmHg	mmHg	mmHg

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E. HEALTH Cont.	**DETAILS of "Yes" answers.**
	If any answer is "Yes", kindly provide full details of adverse findings and opinions

7. **Pulse**
Peripheral Pulses: _____
(If pulse is irregular or pulse > 90 or < 50 minutes, record 3 readings)

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

8. **Heart**
Apex beat in _____ intercostals space _____ cm to the (☐ right ☐ left)
of the Midsternal line.

a. Is the heart enlarged?	☐ Yes	☐ No
b. Is there any: i. Arteriosclerosis of aneurysm?	☐ Yes	☐ No
ii. Hypertrophy or oedema?	☐ Yes	☐ No
iii. Murmur *(if murmur is present, describe below)*	☐ Yes	☐ No

Location:	☐ Parasternal	☐ Apex	☐ Aortic area	☐ Base	☐ Pulmonary area
Timing:	☐ Systolic	☐ Diastolic	☐ Presystolic	☐ Pansystolic	☐
Intensity:	☐ Soft	☐ Moderate	☐ Loud	☐	☐
Transmission:	☐ None	☐ Axilla	☐ Scapula	☐	☐
After exercise:	☐ Absent	☐ Increased	☐ Decreased	☐ Unchanged	☐

c. Diagnosis _____

d. Is there excessive dyspnea after exercise? ☐ Yes ☐ No

e. Do you suspect any abnormality in the heart or vascular system upon review of your overall findings? ☐ Yes ☐ No

9. a. Are you aware of any unfavorable features likely to affect the applicant longevity
i. In the personal of family history? ☐ Yes ☐ No
ii. Disclosed by your medical examination? ☐ Yes ☐ No
b. Do you recommend any additional tests or reports? ☐ Yes ☐ No
c. Do your know any facts about his risk not brought up earlier? ☐ Yes ☐ No

d. What is your general impression of the applicant after completing your medical examination?

10 Do you have any reason to believe that the applicant is a higher than average risk for AIDS ? If so why? ☐ Yes ☐ No

F. DECLARATION

I hereby certify that I have personally verified the identity of the applicant whom I have examined. This examination has been conducted in private at:

Clinic Name and address: _____

on the _____ day of _____ 20 _____ at _____am/pm.

_____
Signature of Examiner
Name:
NRIC No:
Date:
Clinic Rubber Stamp