

PHYSICIAN EXAMINATION REPORT

FOR APPLICANTS OVER AGE 65 ONLY

to be submitted directly to
Pacific International Insurance Company Limited
c/o International Administrators Limited
16/F, 9 Des Voeux Road West, Sheung Wan, Hong Kong, SAR
Tel.: (852) 2573-2535 Fax: (852) 2573-2917 E-mail: inquiry@ialhk.com

Note: Please complete in full and mail this form to Pacific. Non-Pacific Pre-Approved Doctors will need to submit Board certifications and license information along with this report.

PART I (TO BE FILLED OUT BY THE APPLICANT)

Name: Last _____ First _____ Middle _____

Address: _____

Tel: _____ Fax: _____ E-mail: _____

Date of Birth (MM/DD/YY): _____ Age: _____ Sex: _____

Country of Citizenship: _____ Country of Residence: _____

Father's Name: _____ Mother's Name: _____

If Deceased, Cause of Death: _____ If Deceased, Cause of Death: _____

No. of Siblings: _____ If Any Sibling is Deceased, Caused of Death: _____

Medicare Coverage: YES NO

This note gives the physician permission to report any medical information requested to Pacific International Insurance Co. Ltd. or its administrators.

Signature of Applicant

Date (MM/DD/YY)

PART II (TO BE FILLED OUT BY PHYSICIAN)

II-A MEDICAL QUESTIONNAIRE: (Mark "Yes" or "No" and circle the specific item)

	YES	NO		YES	NO
1. Weight loss/weight gain for the past 6 months	<input type="checkbox"/>	<input type="checkbox"/>	6. Frequent/painful urination, change in caliber of urine/hematuria, passage of stone	<input type="checkbox"/>	<input type="checkbox"/>
2. Unexplained headache/dizziness, seizure, localized weakness or numbness	<input type="checkbox"/>	<input type="checkbox"/>	7. Abnormal vaginal discharge or bleeding, painful/abnormal menstruation, breast pain	<input type="checkbox"/>	<input type="checkbox"/>
3. Blurring of vision, recurrent rhinitis, sorethroat, ear discharge or decreased hearing sensation	<input type="checkbox"/>	<input type="checkbox"/>	8. Joint pain, non healing wound, change in color of extremities, claudication, cramps, edema	<input type="checkbox"/>	<input type="checkbox"/>
4. Painful swallowing, recurrent abdominal pain, change in bowel habit and caliber of stool, hematemesis, hematochezia or melena	<input type="checkbox"/>	<input type="checkbox"/>	9. Ecchymoses, petechia, easy bruisability, gum or nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>
5. Chest pain, choking sensation, shortness of breath, easy fatigability, orthopnea or paroxysmal nocturnal dyspnea	<input type="checkbox"/>	<input type="checkbox"/>	10. Allergies, history of angioneurotic edema or any anaphylactic reaction	<input type="checkbox"/>	<input type="checkbox"/>

Details: _____

ADDITIONAL INFORMATION:

SOCIAL HISTORY:

	YES	NO	
SMOKING	<input type="checkbox"/>	<input type="checkbox"/>	Details: _____
ALCOHOL INTAKE	<input type="checkbox"/>	<input type="checkbox"/>	Details: _____
ANY FORM OF EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>	Details: _____

