PHYSICIAN EXAMINATION REPORT

• FOR APPLICANTS OVER AGE 65 ONLY •

to be submitted directly to
Pacific Cross Insurance Company Limited
c/o International Administrators Limited
11/F, O.T.B. Building, 160 Gloucester Road, Wanchai, 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 Cross. Non-Pacific Cross 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, Cause of Death: _____

Medicare Coverage: YES ❑ NO ❑

This note gives the physician permission to report any medical information requested to Pacific Cross 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
1. Weight loss/weight gain for the past 6 months	❑	❑
2. Unexplained headache/dizziness, seizure, localized weakness or numbness	❑	❑
3. Blurring of vision, recurrent rhinitis, sorethroat, ear discharge or decreased hearing sensation	❑	❑
4. Painful swallowing, recurrent abdominal pain, change in bowel habit and caliber of stool, hematemesis, hematochezia or melena	❑	❑
5. Chest pain, choking sensation, shortness of breath, easy fatigability, orthopnea or paroxysmal nocturnal dyspnea	❑	❑
6. Frequent/painful urination, change in caliber of urine/hematuria, passage of stone	❑	❑
7. Abnormal vaginal discharge or bleeding, painful/abnormal menstruation, breast pain	❑	❑
8. Joint pain, non healing wound, change in color of extremities, claudication, cramps, edema	❑	❑
9. Ecchymoses, petechia, easy bruisability, gum or nose bleeding	❑	❑
10. Allergies, history of angioneurotic edema or any anaphylactic reaction	❑	❑

Details: _____

ADDITIONAL INFORMATION:

_____

_____

SOCIAL HISTORY:	YES	NO	
SMOKING	❑	❑	Details: _____
ALCOHOL INTAKE	❑	❑	Details: _____
ANY FORM OF EXERCISE	❑	❑	Details: _____

FAMILY HISTORY:

_____

_____

_____

PAST MEDICAL HISTORY (confinements, previous illness, etc.):

_____

_____

_____

II-B PHYSICAL EXAMINATION REPORT: (Please comment on each area)

1. VITAL SIGN: BP: (SITTING) _____ (STANDING)_____ HR:_____ /MIN TEMPERATURE :_____ °C
   HEIGHT: _____cm WEIGHT: _____kg
2. HEENT: EYES _____
   FUNDOSCOPY _____
   NOSE _____ NECK/THROAT _____
   EARS _____
3. LUNGS: _____
4. BREAST EXAMINATION (for female):_____
5. HEART: _____
6. ABDOMEN:_____
7. EXTREMITIES:_____

DIAGNOSTIC TEST RESULTS: (copies of relevant results are required)

A. CHEST X-RAY: _____
B. 12 LEAD ECG: _____
C. ROUTINE URINALYSIS (Micro): _____
D. COMPLETE BLOOD COUNT (CBC):_____
E. LIPID PROFILE: _____
F. LIVER FUNCTION TEST (SGPT, SGOT, GGT, Alkaline phosphate, Bilirubins, Albumin): _____
_____
G. KIDNEY FUNCTION TEST (BUN, Creatinine, Uric Acid): _____
H. THYROID FUNCTION TEST (T3 & T4): _____
I. FASTING BLOOD SUGAR: _____ J. HbAlc: _____
K. HEP TESTS (B & C):_____ L. HIV: _____
M. PSA (MALE):_____ N. PAP SMEAR (FEMALE):_____

ADDITIONAL TEST RESULTS (to be done if indicated): (copies of relevant results are required)

A. 2-D ECHO CARDIOGRAM WITH DOPPLER:_____
B. TREADMILL STRESS TEST:_____
C. BILATERAL MAMMOGRAPHY ULTRASOUND (for female): _____
D. URINALYSIS (C & S): _____
E. ABDOMINAL ULTRASOUND:_____
F. ALPHA FETO PROTEIN: _____

IMPRESSION:

_____

_____

_____

_____

_____ _____ _____

Signature of Attending Physician *Name of Physician* *Date (MM/DD/YY)*