



## Medical Statement

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Producer: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State: \_\_\_\_\_ City, State: \_\_\_\_\_

Phone #: \_\_\_\_\_

Producer Code #: \_\_\_\_\_ Policy #: \_\_\_\_\_

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### Insured Information

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name/Address of Family Physician \_\_\_\_\_

Physician's Phone \_\_\_\_\_ Years Under Care: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

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### Medical History

#### Eye Sight

Has patient lost use/sight of either eye?  Yes  
 No

Is peripheral(side) vision restricted?  Yes  
 No

Is patient color blind?  Yes  
 No

Does patient have cataracts?  Yes  
 No

Has patient ever had cataracts?  Yes  
 No

Are sight deficiencies corrected by eye wear?  Yes  
 No

Date of last eye examination - \_\_\_\_\_

#### Blood Pressure

Has patient ever been treated for high blood pressure?  
 Yes  No If yes, date of treatment - \_\_\_\_\_

Last reading? \_\_\_\_\_

Medication / dosage used? \_\_\_\_\_

#### Miscellaneous

(if applicable, date of last treatment)

Convulsions - \_\_\_\_\_

Fainting Spells - - \_\_\_\_\_

Loss of Equilibrium - \_\_\_\_\_

Alcohol / Drug Abuse - \_\_\_\_\_

**Hearing**

Can patient hear normal conversation level?  Yes  No

Is hearing aid used?  Yes  No

**Heart**

Has patient ever been treated for heart disease?  Yes  No

Has patient ever has a heart attack?  Yes  No

Does patient have a pacemaker?  Yes  No

Medication / dosage used? \_\_\_\_\_

When was last treatment or check-up?  Yes  No

**Limbs**

Loss of any arm or leg?  Yes  No

Loss of use of any arm or leg?  Yes  No

Does patient's vehicle have special controls?  Yes  No

If any above please describe? \_\_\_\_\_

**Diabetes**

Has patient ever been tested for diabetes  Yes  No

Latest blood / sugar test date - \_\_\_\_\_

Medication / dosage used? \_\_\_\_\_

Method of Administration? \_\_\_\_\_

**Epilepsy**

Has patient ever been treated for epilepsy?  Yes  No

If yes, kind and date of last seizure?  Yes  No

Medication / dosage used? \_\_\_\_\_

Mental / Emotional Illness - \_\_\_\_\_

Complete Physical Exam - \_\_\_\_\_

**If any of the following are "Yes" please provide a complete explanation.**

Has the patient ever been treated or received medication for any neurological, mental, or emotional problems?

Yes  No

Has the patient ever been treated or received medication for a neuromuscular disease (Musular Distrophy, Multiple Scherosis, Cerebral Palsy, etc?)  Yes  No

Are there any restrictions posted on driver's licenase other than glasses?  Yes  No

Is patient under the care of a physician for any condition not mentioned above?  Yes  No

In physician's opinion, this patient is capable of safely operating a motor vehicle?  Yes  No

Signature of Physician \_\_\_\_\_

Date: \_\_\_\_\_