

MEDICAL POLICY



MEDICAL EXAMINATION FORM

The Jubilee Insurance Company of Kenya Limited Head Office:

Jubilee Insurance House, Wabera Street,
P.O. Box 30376 - 00100 GPO, Nairobi, Kenya
Email: jic@jubileekenya.com

Mombasa:

Jubilee Insurance Building, Moi Avenue,
P.O. Box 90220 - 80100, Mombasa, Kenya
Email: mombasa@jubileekenya.com

Kisumu:

Jubilee Insurance House, Oginga Odinga Road,
P.O. Box 378 - 40100, Kisumu, Kenya
Email: kisumu@jubileekenya.com

DIRECTIONS:

Please read carefully and fill out the entire form.

1. This form must be completely and legibly filled out in BLOCK letters in order for us to process your claim.

This form will remain strictly confidential.

PERSONAL DETAILS

Full name Sex Male Female

ID or Passport No Date of birth

Postal Address Postal Code Email:

Tel (Office) Res Cellphone

Personal physician Tel

Corporate/ Individual Membership (indicate Corporate Name)

Name of Agent/ Broker

Signature of the examinee Date

Reason for medical examination (please tick):

New Reinstatement Upgrade Over 65 years Other

HAVE YOU EVER HAD (If Yes, tick item and record the date, treatment, results, name and address of Doctor and Hospital. Space is provided in the next page.)

- | | | | | |
|--------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Fits/ fainting | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Severe head aches | <input type="checkbox"/> Any mental/ nervous disorder | <input type="checkbox"/> STD |
| <input type="checkbox"/> Bronchitis or asthma | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Any other lung complaint |
| <input type="checkbox"/> Piles | <input type="checkbox"/> Malaria | <input type="checkbox"/> Typhoid/ amoebiasis | <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pain in chest | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Severe/ recurrent indigestion | <input type="checkbox"/> Gastric/ duodenal ulcer | <input type="checkbox"/> Any other GIT complaint |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Renal colic | <input type="checkbox"/> Disease of kidney, liver, pancreas or bladder | <input type="checkbox"/> Any operation, x ray or special inv | <input type="checkbox"/> Serious injury/ loss of consciousness/ fracture |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Recurrent/ persistent fever | <input type="checkbox"/> Skin disorder | <input type="checkbox"/> Unexplained persistent night sweats | <input type="checkbox"/> Genital sores/ discharge |
| <input type="checkbox"/> Cancer treatment | | | | |

Have you ever been treated with (please tick):

Steriods

Anthypertensive drugs

When is the last time you had an HIV Test?

Result

Have been admitted to hospital in the last 3 years? Yes

No

If yes, give name and address of hospital and reason.

Have you ever been refused as a blood donor?

Yes No

Have you received a blood transfusion within the last 5 years?

Yes No

Give details of all positive answers.

SOCIAL HISTORY

Marital status

Where applicable, cause of death of spouse

Number of children

Profession

HABITS

Units of alcohol/sitting

No. of cigarettes/day

Duration of smoking

If female:-

Menstrual cycle – duration, flow, abnormality

Contraception history

Family history of any of the following diseases (please tick)

- | | | | |
|-------------------------------------------------------------|---------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Ischaemic heart disease conditions | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bronchial asthma | <input type="checkbox"/> Allergic skin |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Sudden death | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Raised cholesterol | | |

GENERAL APPEARANCE

Height: cm

Chest/Waist measurement Ratio:

Weight: kg

Hip measurement: cm

BMI:

Healthy, looks declared age?

Morphological type?

	YES	NO	COMMENTS
Are there any malformations or mutations?			
Are there any stigmata of alcohol, tobacco, or drug abuse?			
Are there any repercussions of the proper's professional or social activities on the general state of health?			
RESPIRATORY SYSTEM			
Previous history?			
Are there signs of decreased chest expansion?			
Are there signs of abnormal dullness to percussion?			
Are there abnormal auscultatory signs?			
Is the voice normal?			
NECK: Is there evidence of goitre?			
Is there any lymphadenopathy?			
CARDIOVASCULAR SYSTEM			
Previous history?			
Is the heart enlarged?			
Are the heart sounds normal? (intensity, splitting, etc)			
Are there any cardiac murmurs?			<input type="checkbox"/> Systolic <input type="checkbox"/> Intensity <input type="checkbox"/> Diastolic
Does the murmur seem to be pathological?			
Does the murmur radiate?			
Where is the maximal intensity?			
Does the abdominal aorta seem dilated?			
Are the peripheral pulses all present and symmetrical?			
Are there any arterial bruits in the cervical and femoral regions?			

BLOOD PRESSURE

Systolic: Diastolic: with treatment without treatment

Pulse rate: Extrasystoles

If the blood pressure is over 140/90 mmHg, please check the reading after ten minutes lying down.

	YES	NO	COMMENTS
GASTROINTESTINAL SYSTEM			
Previous history?			
Are there any abnormalities of the mouth, tongue, pharynx or tonsils?			
Are there any abnormalities of the abdomen on palpation and percussion?			
Hepatomegaly?			Degree: Consistency:
Splenomegaly?			
Are there any abnormalities of the hernial orifices?			
Are there signs of haemorrhoids, previous melaena or rectal bleeding?			
GENITO URINARY SYSTEM			
Previous history?			
For men:			
Are there any signs of disease of the genital organs (testis, epididymes, prostate)?			
Is there gynaecomastia?			
For women:			
Are there any signs of gynaecological disease?			

Are there any abnormalities of the breast?			
CENTRAL NERVOUS SYSTEM			
Previous history?			
Sequellae?			
Are the papillary, abdominal or tendon reflexes abnormal?			
Are there any signs of autonomic nervous dysfunction?			
Are there any psychiatric or neurological abnormalities?			
SKIN AND TEGUMENTS			
Are there any signs of jaundice or cyanosis?			
Skin eruption, cyst, tumour, varicosities or oedema?			
Lymphadenopathy?			
Scars or tattoos?			
Tophi and xanthomata?			
SKELETAL SYSTEM			
Are there any abnormalities of the bones, joints, or intervertebral discs?			
SENSORY ORGANS			
Is there any disease of the eyes?			
Visual acuity? R L			
Before correction /6 /6			
After correction /6 /6			
Is there any disease of the ears?			
Is the examinee currently under medical treatment?			Which? Since when? Why?
CONCLUSIONS			
Do you have any reserves concerning the longevity of the examinee?			
Are there any risks on invalidity or partial, or total disability?			

The proposer's state of health is considered to be:
 GOOD AVERAGE POOR

STANDARD MEDICAL TESTS REQUIRED (please tick)

Basic tests

Full Blood Count and ESR Yes No
Fasting Blood Sugar Yes No
Urinalysis Yes No

Additional Tests

Lipid Profile Yes No
PSA (for Men) Yes No
Pap Smear (for Women) Yes No
Urea & Electrolytes Yes No
Liver Function Test Yes No
GTT Yes No
Glycosylated Haemoglobin Yes No

Name of Examiner

Institution

Signature

Date