

| 3. Physician who drew up the report | |
|--------------------------------------------|-----------------------------------|
| 3.1 | Last name _____ |
| 3.2 | First name _____ |
| 3.3 | Middle name (if applicable) _____ |
| 3.4 | Address _____ _____ |
| 3.5 | Examining physician of |
| | |

| 4. Patient's history | |
|-----------------------------|------------------------------------------|
| 4.1 | Medical history |
| | |
| 4.2 | Current chief complaints |
| | |
| 4.3 | Physician currently treating the patient |
| | |
| 4.4 | Current treatment |
| | |
| 4.5 | Social and employment history |
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|-----|-----------------------------------------------------|----------------------------------------------------------|-----------------------------------------|
| 4.6 | Is the insured person currently gainfully employed? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Number of working hours: _____ _____ |
| | Type of actual employment | | |
| 4.7 | Accidents at work/occupational diseases | | |
| 4.8 | Type of last employment: | | |
| 4.9 | Unfit for work | <input type="checkbox"/> since (Date): _____ | |
| | Cessation of work | <input type="checkbox"/> since (Date): _____ | |

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|-----------|----------------------------|-------------------------------------------|--------------------------------------------------------------------------|
| 5. | Findings | | |
| 5.1 | General physical condition | | |
| | Height (in cm.) | Weight (in kilos) | |
| | Nutritional condition: | <input type="checkbox"/> good | <input type="checkbox"/> overweight <input type="checkbox"/> underweight |
| | | <input type="checkbox"/> Mucous membranes | <input type="checkbox"/> Mental status <input type="checkbox"/> Mood |
| | Remarks | | |
| | _____ | | |
| | _____ | | |
| 5.2 | Head | | |
| 5.3 | Vision | | |

| | |
|------|---------------------------------------------------|
| 5.4 | Hearing |
| 5.5 | Other sensory organs |
| 5.6 | Neck (external findings) |
| 5.7 | Review of thyroid gland |
| 5.8 | Lymphatic nodes |
| 5.9 | Others |
| 5.10 | Other sensory organs |
| 5.11 | Circulatory system |
| 5.12 | Heart |
| 5.13 | Pulse |
| 5.14 | Blood pressure (at rest) |
| 5.15 | Blood pressure (second measurement) |
| 5.16 | Peripheral blood vessels |
| 5.17 | Oedema |
| 5.18 | ECG (at rest) |
| 5.19 | Abdomen |
| 5.20 | Digestive system and linked endoabdominale organs |

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|-----------------------------------------------------------------------------------|
| 6. Function and other tests (when necessary) |
| 6.1 Lung function |
| 6.2 Cardiac function/exercise ECG |
| 6.3 Doppler ultrasonography (heart and vessels) |
| 6.4 Findings in today's X-rays examination |
| 6.5 Earlier findings/X-ray examinations done elsewhere |
| 6.6 Ultrasonography (abdomen, et al) |
| 6.7 MRI and special investigations |
| 6.8 Laboratory results |
| 6.9 Other tests |

7. Additional sheet for further specialists findings (shall be filled out only if relevant)

8.

Diagnosis

(ICD code recommended)

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9.

Summary

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Course of disease

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Damage to health

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Functional deficits

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Compared with previous report (dated)

improvement

worsening

no change

10.

The insured person is still capable of regularly performing the following types of work:

heavy

average

light

11.

Is re-examination necessary in the future?

Yes

No

If yes, please state when:

.....

Physician's signature

Date, Seal