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## PHYSICIAN EXAMINATION REPORT

FOR APPLICANTS OVER AGE 65 ONLY

**NOTE: Please complete in full and mail this form to Pacific Cross Vietnam. Non-Pacific Cross Vietnam 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 (day/month/year): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_ Country of Residence: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

If Deceased, Caused of Death: \_\_\_\_\_ If Deceased, Caused 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 Cross Vietnam**.

Signature of Applicant: \_\_\_\_\_ Date (day/month/year): \_\_\_\_\_

### 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, hemochezia 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: _____

**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. HbA1c: \_\_\_\_\_
- 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 (day/month/year)