GLOBALITY HEALTH
premium health insurance worldwide

Medical Examination Report

Globality S.A.
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Commercial Register (R.C.S. Luxembourg): B 134.471

Medical examination (to be filled out by the physician)

Policy No.	Provided by	Agent No.

A spouse, parent, sibling or child of the patient may not carry out the examination. The applicant has to pay for the examination costs.
Please use block letters and write legibly. Thank you.

I. Details of insured person

First and last name	
Date of birth	
Address	
Present Occupation	

II. General questions to be completed by the physician (please provide scientific diagnoses – do not cross out)

1. Since when has the patient been in your treatment?	

For what diseases, complaints or accidents has the patient been treated in the past 5 years
(please cite time periods (from – to) for all information)

a) according to anamnesis	
b) according to the medical history in your own records?	
Was the patient tested for AIDS, allergies, diabetes etc.? If so, what were the results?	

2. When did you first inform the patient about your findings?

3. Was or is treatment – also by other physicians – necessary or advisable?

Name and address of the other treating physician

a) why? (diagnosis)

b) From – to?

4. Is the patient unable to work, carry out millitary service or in another way disabled? If yes, what findings?

☐ Yes ☐ No

5. Name and address of the family doctor

How long are you with this doctor?

6. If you should have any other medical reports, we would appreciate it if you would allow us to view them, we guarantee immediate return.

a) We also request that you enclose any laboratory findings from the past 12 months.

b) If you have no laboratory findings from the past 12 months, we ask that the following examination be made:
Partial blood count (erythrocytes, haematocrit, haemoglobin, MCV, leukocytes), PTT, Quick, Cholesterol, HDL-cholesterol, LDL-cholesterol, Triglyceride, Uric acid, Creatinine, Alkaline phosphatase, Gamma-GT, GOT, GPT, HbA1 or HbA1c, fasting glucose, CRP

c) In the case of increased transaminases (GOT and GPT values) please provide the following supplemental values:
HBs antigen, antibodies against HCV

III. General and organ findings

7. Height and weight _____ cm _____ kg

8. Is cardio-vascular system healthy? ☐ Yes ☐ No
   If not, what findings?

9. Blood pressure at rest Systolic _____ Diastolic _____

   Please repeat measurement if result is over 135/85.

   Blood pressure 2nd measurement Systolic _____ Diastolic _____

10. Pulse At rest _____
    After 10 knee bends _____
    After 2 minutes _____

11. Are the eyes, nose, ears, mouth and throat healthy? ☐ Yes ☐ No
    If not, what findings?

12. Are the lungs healthy? ☐ Yes ☐ No
    If not, what findings?

13. Are the skeletal system and joints healthy? ☐ Yes ☐ No
    If not, what findings?

14. Is the nervous system healthy, and is the mental behaviour normal? ☐ Yes ☐ No
    If not, what findings?

15. Are the digestive organs (stomach, liver, gall bladder, intestines, liver, gall bladder, intestines, pancreas) healthy? ☐ Yes ☐ No
If not, what findings?

16. Are the kidneys, urinary organs and sex organs healthy? ☐ Yes ☐ No
If not, what findings?

17. Urine findings

Protein	☐ Yes	☐ No
Blood	☐ Yes	☐ No
Sugar	☐ Yes	☐ No
Sediment	☐ Yes	☐ No

18. Are the signs of metabolic disorders, in particular of the thyroid? ☐ Yes ☐ No
If yes, what findings?

19. Are there skin or mucous membrane abnormalities? ☐ Yes ☐ No
If yes, type/localisation

20. Are there venous disorders? ☐ Yes ☐ No
If yes, what findings?

21. Woman only: Is the patient pregnant? ☐ Yes ☐ No

If yes, week?

When was the pregnancy first determined?

Name and contact details of the treating doctor. (Please enclose a copy of the maternity pass or gynaecologist report)

Are there

a) Diseases of the breasts or reproductive system? ☐ Yes ☐ No
If yes, what findings?

b) Hormonal or menstrual problems? ☐ Yes ☐ No
If yes, what findings?

22. Are there any other health problems, pathological aberrations, malformations or problems caused by previous accidents? ☐ Yes ☐ No
If yes, what findings?

23. What, if any, diagnostic measures are necessary or advisable and for what reason?
(Treatment/diagnosis)

24. Overall impression and assessment

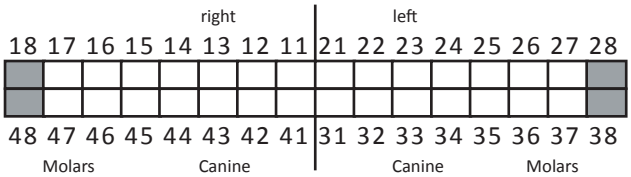
IV. Dental findings

25. Are the teeth healthy or well treated? ☐ Yes ☐ No

26. Are gum diseases recognisable? ☐ Yes ☐ No

27. Are treatments of the teeth or gums, dentures or orthodontic measures necessary? ☐ Yes ☐ No
If yes, what findings?

Findings:
f = missing teeth
e = replaced teeth
z = treatment needed/recommended



Maxillary
Mandibular

28. Address of the treating dentist/orthodonist

Place and date of examination

(please sign and stamp corrections separately)

Stamp

Signature of the physician