THE NEW INDIA ASSURANCE CO. LTD. | UNITED INDIA INSURANCE CO. LTD. | THE ORIENTAL INSURANCE CO. LTD. | NATIONAL INSURANCE CO. LTD. | & Private Insurance Companies

Adroit Consultancy Medicolegal Services

Prathamesh Horizon, New M.H.B. Colony, New Link Road, Opp. Don Bosco School,
Borivali (W), Mumbai - 400091 • Tel : 2867 8736 / 93239 14877 E-mail : drmdg1973@gmail.com

PREINSURANCE HEALTH CHECK UP MEDICAL EXAMINATION REPORT

No.

PART-A. PRELIMINARY DATA DATE _____

NAME: _____

Age : _____ yrs; Sex: _____ Contact Nos : _____

Address: _____

_____

Document Verified for identity: Ration Card/ Voters Card/Passport/Driving license/Pan card (☑)

PART-B: INSURANCE COMPANY DETAILS

Name of the Insurance Company_____
Regional Office : _____Divisional Office_____Area : _____
Development Officer Code: _____Agents Code _____Agents Name_____

PART C : MEDICAL EXAMINATION (FILLED BY THE MEDICAL EXAMINER)

Any past,h/o/since: (☑ against positive history) (Put ☒ against negative history)

High B.P. ☐	Thyroid disease ☐	Glaucoma ☐	STD ☐	Dental Problems ☐
Diabetes ☐	Epilepsy ☐	Cancer ☐	Drug allergy ☐	Tuberculosis ☐
Heart Disease ☐	Stroke ☐	Skin Disease ☐	Arthritis ☐	Rheumatic dis ☐
Peptic Ulcer ☐	Hernia / Hydrocele ☐	Menstrual Irregularities ☐	Asthma ☐	Psychiatric disease ☐

Past hospitalization/Surgery history if any:

Family History: _____

Medication intake if any : _____

I hereby declare that the information disclosed by me is true and correct. I am authorizing to disclose information to the insurance Company/ concerned authorities.

Date: _____ Signature of the proposer _____

PART D: GENERAL EXAMINATION

Body wt :_____Kgs Height:_____cms Pulse_____/min B.P:_____/_____mmHg

Ophthalmic Examination	Rt eye	Left eye
Cataract		
Glaucoma		
Refractive error		