

MEDICAL EXAMINATION FORM

Examination should not be performed by a spouse, parent, sibling or child of the examinee.
Charges will be made to the person who makes the application.
A dash is not accepted as an answer.

Insurance No.

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A. Identity of examinee

First name	Current profession/Title
Family name	Address Street, House number
Day/Month/Year of birth	Postcode, Town

B. Medical questionnaire

1. Diseases, complaints, accidents, aids test, allergies, diabetes, according to anamnesis of examinee.			
1.1 Test results			
1.2 Treatment/co-treatment being done by?			
1.3 Duration of treatment from – to			
1.4 When was the patient informed for the first time about the results by yourself/the co-attending person?			
2. Is there a disability?	<input type="checkbox"/> no	<input type="checkbox"/> yes	if yes, your statement:
3. Height and weight	cm	kg	

For persons up to 16 years

4. Do you consider the child to be in good health and is it free of abnormalities, infirmities and malformations (including jaw abnormalities) and wrongly positioned teeth?	<input type="checkbox"/> yes	<input type="checkbox"/> no	if no, your statement:	
4.1 Which diagnostical procedures are perhaps necessary and, if so, why?				
4.2 Which treatments were/are at present necessary or recommended?				
4.3 Address of the treating doctor and/or of the dental surgeon	1 Name	Street, House number	Postcode, Town	
	2 Name	Street, House number	Postcode, Town	

For persons over 16 years

Medical/Clinical report concerning the organs

5. Do you consider the respiratory organs to be in good condition?	<input type="checkbox"/> yes	<input type="checkbox"/> no	if no, your statement:	
6. Blood pressure at rest	systolic	diastolic	Abnormality	
7. Pulse	at rest	after 10 genuflexions	after 2 minutes	Abnormality
8. Do you consider the heart, vessels and circulatory system to be in good health?	<input type="checkbox"/> yes	<input type="checkbox"/> no	if no, your statement:	
9. Do you consider the skeletal and articular system to be in good condition?	<input type="checkbox"/> yes	<input type="checkbox"/> no	if no, your statement:	

Dental condition at visual inspection

You may also send the examination certificate to the DKV Luxembourg – department for applications –

Place and date of the examination	Stamp and signature of the doctor
Handed over by	Agent