

# DOCTOR'S STATEMENT FOR 70+ CUSTOMERS

To be completed by the doctor with minimum qualifications of MD (Medicine) / DM (Cardiology). Registration stamp is also required. MD (Pathology) & MD (Radiology) should not perform this examination.

## PART 1 - HISTORY OF THE PROPOSER

1. Any past history of disease, surgery, accidents, investigation etc.
  
2. Please detail any treatment taken by the proposer in the past or being taken at present

## PART 2 – EXAMINATION

### 3. General Examination:

a) Height: \_\_\_\_\_ b) Weight: \_\_\_\_\_ c) Pulse: \_\_\_\_\_

d) BP: \_\_\_\_\_ e) Respiratory Rate: \_\_\_\_\_ f) JVP: \_\_\_\_\_

g) Evidence of (Please tick wherever applicable)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Icterus                    | <input type="checkbox"/> Cyanosis         |
| <input type="checkbox"/> Clubbing             | <input type="checkbox"/> Pedal Odema                | <input type="checkbox"/> Enlarged Thyroid |
| <input type="checkbox"/> Enlarged Lymph Nodes | <input type="checkbox"/> Obvious defect / deformity |   |

Any other positive finding on general examination: \_\_\_\_\_

### 4. Systematic Examination:

a. AS: \_\_\_\_\_

b. RS: \_\_\_\_\_

c. CVS: \_\_\_\_\_

d. CNS: \_\_\_\_\_

e. Musculoskeletal System: \_\_\_\_\_

Please detail all the +ve findings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PART 3 – ELECTROCARDIOGRAPHY

5. Does the attached electrocardiogram in your professional opinion show any abnormalities? If so, please give details.
  
6. Does the abnormality represent a current illness or disease that may possibly require medical treatment during the proposer's forthcoming trip?
  
7. Does the proposer now or did he/she in the past, require medication for this abnormality?
  
8. Do you consider that the proposer is fit to travel anywhere abroad, due account being taken of the stress of air travel adversely affecting his/ her health/ medical condition?

9. Details of Client:

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Age:

\_\_\_\_\_

I declare that all the particulars and information given in this form (and all documents referred or provided therewith) are true, correct, complete and up-to-date in all respects and I have not withheld any information. I further agree and undertake to provide any further information that ICICI Lombard General Insurance Company may require in relation to the said details

Name \_\_\_\_\_ of \_\_\_\_\_ the \_\_\_\_\_ Doctor:

Qualification: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date: \_\_\_\_\_

**SIGNATURE  
&  
RUBBER STAMP  
OF  
DOCTOR**

