



# Medical Report

Individual Underwriting Department  
P.O. Box 9041  
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Each person on the Individual Enrollment Application must submit a separate completed Medical Report.

Applicant Name

**Medical History – This form must be completed in its entirety by a participating Blue Cross physician.**

Date of Exam: \_\_\_\_\_ (must be within 12 months of application date)

Please check any of the following as they apply and provide dates, hospitalization, and other pertinent details in the space provided under "Explanation" below. You may also include copies of the patient's medical records.

- Heart Disease
- Pulmonary Disease
- Cancer
- Tuberculosis
- Diabetes Mellitus
- AIDS/ARC
- Seizure Disorder
- Alcohol Abuse
- Drug Abuse
- Participation in a drug or alcohol rehabilitation program
- Mental Illness
- Counseling
- Neurological Disorder
- Other injuries, surgeries or illnesses

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Does this patient have any future surgery or hospitalization planned?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is the patient currently on any medication(s)?  Yes  No If yes, indicate name, dosage and reason for medication(s): \_\_\_\_\_  
\_\_\_\_\_

**Laboratory**

List the following laboratory results or attach a copy of the lab report(s):

Cholesterol Date: \_\_\_\_\_ Results: TC \_\_\_\_\_ HDL \_\_\_\_\_ LDL \_\_\_\_\_

Triglycerides Date: \_\_\_\_\_ Results: \_\_\_\_\_

Blood sugar Date: \_\_\_\_\_ Results: \_\_\_\_\_

Hematocrit or Hemoglobin Only Date: \_\_\_\_\_ Results: \_\_\_\_\_

Serum Creatinine Date: \_\_\_\_\_ Results: \_\_\_\_\_

**Physical Examination**

Age	Height	Weight	Pulse	Respiration	BP
Please indicate (+) if abnormal or (-) if normal as they apply and provide details in space provided.					
HEENT	Hearing	Abdomen	Neurological	Heart	
Sight	Skin	GU	Lungs	OB/GYN	

Explanation of any abnormal findings: \_\_\_\_\_  
\_\_\_\_\_

Name of Attending Physician (Please Print)	Degree/Licensure		Telephone
Street Address	City	State	ZIP Code
Signature	Provider Number		Date