VENTURE
GENERAL AGENCY LLC

Medical Statement

Producer:
Address:
City, State:
Phone #:
Producer Code #:

Insured Name:
Address:
City, State:

Policy #:

Insured Information

Date of Birth: _____ Age: __ Sex: __ Occupation: ___

Name/Address of Family Physician _____

Physician's Phone #:_____ Years Under Care:_____Date of Last Visit: _____

Medical History

Eyesight

Has patient lost use/sight of either eye?	☐ Yes ☐ No
Is peripheral (side) vision restricted?	☐ Yes ☐ No
Is patient color blind?	☐ Yes ☐ No
Does patient have cataracts?	☐ Yes ☐ No
Has patient ever had cataracts?	☐ Yes ☐ No
Are sight deficiencies corrected by eye wear?	☐ Yes ☐ No

Date of last eye examination - _____

Hearing

Can patient hear normal conversation level?	☐ Yes ☐ No
Is hearing aid used?	☐ Yes ☐ No

Heart

Has patient ever been treated for heart disease?	☐ Yes ☐ No
Has patient ever has a heart attack?	☐ Yes ☐ No
Does patient have a pacemaker?	☐ Yes ☐ No

Medication / dosage used? _____

When was last treatment or check-up? ☐ Yes ☐ No

Limbs

Loss of any arm or leg?	☐ Yes ☐ No
Loss of use of any arm or leg?	☐ Yes ☐ No
Does patient's vehicle have special controls?	☐ Yes ☐ No

If any above please describe?

_____

Diabetes

Has patient ever been tested for diabetes ☐ Yes ☐ No

Latest blood / sugar test date

_____

Medication / dosage used? _____

Method of Administration? _____

Epilepsy

Has patient ever been treated for epilepsy?	☐ Yes ☐ No
If yes, kind and date of last seizure?	☐ Yes ☐ No

Medication / dosage used? _____

Blood Pressure

Has patient ever been treated for high blood pressure?

☐ Yes ☐ No If yes, date of treatment -Last _____

reading? _____

Medication / dosage used? _____

Miscellaneous

(if applicable, date of last treatment)

Convulsions - _____

Fainting Spells - - _____

Loss of Equilibrium - _____

Alcohol / Drug Abuse - _____

Mental / Emotional Illness - _____

Complete Physical Exam - _____

If any of the following are "Yes" please provide a complete explanation.

Has the patient ever been treated or received medication for any neurological, mental, or emotional problems?
☐ Yes ☐ No

Has the patient ever been treated or received medication for a neuromuscular disease (Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, etc?) ☐ Yes ☐ No

Are there any restrictions posted on driver's license other than glasses? ☐ Yes ☐ No

Is patient under the care of a physician for any condition not mentioned above? ☐ Yes ☐ No

In physician's opinion, this patient is capable of safely operating a motor vehicle? ☐ Yes ☐ No

Signature of Physician _____

Date: _____