



## PHYSICIAN'S STATEMENT - DISABILITY CLAIM

*Note: Please use reverse side for answers requiring additional information not called for in this questionnaire. Identify your answers with corresponding item numbers.*

<b>C L A I M A N T</b>	1. Name		<b>D I S A B I L I T Y</b>	16. Is any surgical operation anticipated or has one been performed? If so, What	
	2. Address			When	
	3. Occupation	4. Age		Where	
	5. Height			6. Weight	By Whom
	7. Are you his regular physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			17. What is/are your final and complete diagnosis? (etiologic, anatomic, physiologic, functional)	
	8. How long have you known him? _____ years    _____ months    _____ days			a)	
<b>M E D I C A L  H I S T O R Y</b>	9. When did you first attend to him for his present illness/injury?		<b>P R O G N O S I S</b>	18. What are the current abnormal findings?	
	10. Have you previously attended to him? If so, When _____ For what? _____			a) physical	
	11. Has he been treated by any other physician? If so, give their names and addresses. _____ _____ _____			b) mental/neurologic:	
	12. Previous hospital admission/s and treatment/s/ _____			1. State of consciousness	
	13. What were the earliest indication of illness noted by the injured? (subjective)			2. Appearance and general behavior	
	14. What were your objective findings and assessment?			3. Orientation as to time, place and person	
	15. Work-up done and results, if any.			4. Recent and remote memory recall	
				5. Impairment if any of language	
				6. Motor function - involuntary Movements, gait disturbance, paresis/plegia if any	
				7. Cranial nerve involvement	
		8. Others			
		19. Can the patient...			
		Yes    No			
		<input type="checkbox"/> <input type="checkbox"/> a) wash, bathe, and/or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained?			
		<input type="checkbox"/> <input type="checkbox"/> b) put on and take off, secure and unfasten all necessary garments and any braces, artificial limb or other surgical appliances?			
		<input type="checkbox"/> <input type="checkbox"/> c) move from a bed to an upright chair or wheelchair and vice versa or get on and off a toilet or commode?			
		<input type="checkbox"/> <input type="checkbox"/> d) move from one room to another on a level surface, in the patients normal place of residence?			
		<input type="checkbox"/> <input type="checkbox"/> e) manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained?			
		<input type="checkbox"/> <input type="checkbox"/> f) feed himself once food and drink have been prepared and made available?			
		20. What is the prognosis?			

I, \_\_\_\_\_ hereby certify that the answers  
 (Physician's name in full)  
 given above are full, complete and true, I am a graduate of \_\_\_\_\_  
 (Medical College)  
 \_\_\_\_\_ in the year \_\_\_\_\_.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Insured  
 (must be signed in the presence of attending physician)

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Physician's Address