



A UnitedHealthcare Company

### BLOOD PRESSURE INQUIRY

I hereby authorize the physician who completes this form to release to Golden Rule Insurance Company all information on all medical treatment of me or my children, including information on all medical history of other medical treatment that has been given to this physician.

Date Sent \_\_\_\_\_

ID No. \_\_\_\_\_

Name \_\_\_\_\_

\_\_\_\_\_

Signature of Applicant

Your patient is applying for health insurance. This inquiry is needed to evaluate the insurability of your patient. PLEASE COMPLETE THIS FORM IN ITS ENTIRETY. Please return the completed form to the address on the back. Golden Rule will send you \$20 for the completed form. You must include your Tax ID Number to receive payment.

**A CURRENT EXAM IS REQUIRED IF THE LAST READINGS WERE MORE THAN 12 MONTHS AGO and/or** the patient's blood pressure treatment has been discontinued within the last 12 months and a follow-up has not been obtained.

Most Recent Height/Weight _____ / _____	Date _____	How Long Has Weight Been Stationary _____
Weight One Year Prior _____	Most Recent Total Cholesterol _____	Date _____
Most Recent HDL _____	LDL _____	Most Recent Triglycerides _____ Date _____

**BLOOD PRESSURE READINGS** (start with most recent -- three-year history preferred):

Date	Readings	Date	Readings	Date	Readings
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**CURRENT MEDICATIONS FOR ALL CONDITIONS:**

Name	Dose	Date Prescribed	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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**(CIRCLE ONE)**

- 1. Has there been a medical need to change medication(s) in the past year? ..... Yes No  
If "Yes," please provide details: \_\_\_\_\_  
\_\_\_\_\_
- 2. Any incidents of proteinuria of MORE than a trace? ..... Yes No  
Comments: \_\_\_\_\_
- 3. Any incidents of glycosuria? ..... Yes No  
Comments: \_\_\_\_\_
- 4. Is the patient compliant with your advice and follow-up regimen? ..... Yes No  
If "No," please provide details: \_\_\_\_\_
- 5. Have there been any other cardiovascular disorders? ..... Yes No  
If "Yes," please specify: \_\_\_\_\_
- 6. Has there been any evidence of end organ damage or complications (arrhythmias, bruits, CAD, CHF, diabetes mellitus, LVH, murmurs, neurological damage, PVD, renal disease, retinal damage)? ..... Yes No  
If "Yes," please specify: \_\_\_\_\_
- 7. Have there been other finds you have observed or noted during previous examinations? ..... Yes No  
If "Yes," please provide details: \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

Please print physician's name and address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tax ID Number -- Required for \$20 Payment  
Please return this form directly from your office to:

Golden Rule Insurance Company  
**Attn: New Business Underwriting**  
7440 Woodland Drive  
Indianapolis, IN 46278-1719