Part 2 of Insurance Application

KNIGHTS OF COLUMBUS

A FRATERNAL BENEFIT SOCIETY
1 COLUMBUS PLAZA
NEW HAVEN, CONNECTICUT 06510-3326

MEDICAL QUESTIONNAIRE

To be completed by the medical examiner in his or her own handwriting and signed by the Proposed Insured in the presence of and witnessed by the medical examiner.

PLEASE PRINT ALL ANSWERS

Proposed Insured (Last–First–Middle Initial)	Council No.	Birth Date Month Day Year

Address (Street–City–State/Province) Zip/Postal Code

1. a. Name and address of your personal physician? (If none, so state.)

   b. Date and reason last consulted?

   c. What treatment was given or medication prescribed?

Details of "Yes" answers. (Identify question. Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

	Yes	No
2. To the best of your knowledge and belief do you have, or have you ever had or been treated for: (Circle applicable items and give details.)		
(a) Disorder of eyes, ears, nose or throat?	☐	☐
(b) Dizziness, fainting, convulsions, frequent headache, paralysis or stroke, mental or nervous disorder?	☐	☐
(c) Shortness of breath, persistent hoarseness, cough or bronchitis, blood in sputum, asthma, emphysema, tuberculosis or other disorder of the respiratory system?	☐	☐
(d) Chest pain, irregular heart beat or rhythm, high blood pressure, rheumatic fever, murmur, heart attack or other disorder of the heart?	☐	☐
(e) Chronic indigestion, jaundice, intestinal bleeding; ulcer, colitis, diverticulitis, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
(f) Sugar, albumin, blood or pus in urine; stone or other disorder of the kidney, bladder, prostate or reproductive organs?	☐	☐
(g) Diabetes; thyroid or other endocrine disorders?	☐	☐
(h) Neuritis, sciatica, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
(i) Blood clots, occlusions or any other disorder of veins or arteries?	☐	☐
(j) Tumor, cancer, disorder of skin or disorder of lymph glands?	☐	☐
(k) Anemia, leukemia, coagulation disorders or any other blood disorders?	☐	☐
(l) Use of habit-forming drugs/medication or use of alcohol considered by authorities to be harmful to one's health?	☐	☐
(m) Any other mental or physical disorder not listed above?	☐	☐
3. (a) Have you had any change in weight in the past year?	☐	☐
(b) Are you now under regular observation or taking treatment?	☐	☐
4. Other than as stated in answers above, have you within the past 10 years:		
(a) Had a checkup, consultation, illness, injury or operation?	☐	☐
(b) Been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	☐
(c) Had an electrocardiogram, X-ray or other diagnostic test?	☐	☐
(d) Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐

5. Family history: (any history of diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide.)

	AGE	IF LIVING STATE OF HEALTH (IF POOR, GIVE REASON)	IF DECEASED AGE AT DEATH	IF DECEASED CAUSE OF DEATH
Father				
Mother				
Brothers and Sisters				

	Yes	No
6. Have you used tobacco, in any form, within the past year?	☐	☐
7. Have you ever requested or received a pension, benefits or payment because of a bodily injury, sickness or disability?	☐	☐
8. Females only:		
(a) Have you ever had any abnormality of menstruation, pregnancy or disorder of the female organs or breasts?	☐	☐
(b) Are you now pregnant?	☐	☐

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce the Knights of Columbus to issue the insurance applied for.

Signed at _____ _____
Signature of Proposed Insured

_____ Witness: _____
Date Signature of Medical Examiner

MEDICAL EXAMINER'S VOUCHER – DO NOT DETACH VOUCHER FROM THE REPORT

_____ _____ _____
Please Print Name of Proposed Insured Examined Council No. Date Examined

_____ M.D./D.O.
Please Print Name and address of Medical Examiner

_____
Street City State/Province Zip/Postal Code

MEDICAL EXAMINER

BE SURE TO COMPLETE VOUCHER ON REVERSE SIDE.

MAIL TO:

MEDICAL DIRECTOR
KNIGHTS OF COLUMBUS
1 COLUMBUS PLAZA
NEW HAVEN, CT 06510-3326

MEDICAL EXAMINER'S REPORT

This examination should be made in private. If third person present, give details.

Name

9. HEIGHT (IN SHOES)	WEIGHT (CLOTHED)	MALES ONLY: CHEST (FULL INSPIRATION)	CHEST (FORCED EXPIRATION)	ABDOMEN, AT UMBILICUS RELAXED
FT. IN.	LBS.	IN.	IN.	IN.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

Weight change in past year? _____lbs. ☐ Gain ☐ Loss – Cause?

Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

10. Blood Pressure if over 140/90 take additional readings.

	1st	2nd	3rd
Systolic			
Diastolic 4th phase			
Diastolic 5th phase			

11. Pulse:	1st	2nd	3rd
Rate:			
Irregularities Per Min.:			

12. Heart: (a) Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? ☐ Yes ☐ No

(b) Is heart enlarged? ☐ Yes ☐ No (If yes, describe.)

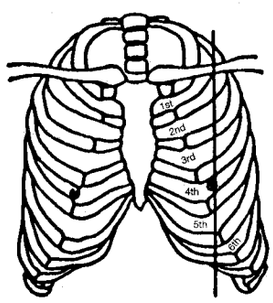
(c) Is murmur present? ☐ Yes ☐ No (If yes, complete 12d.)

(d) Murmur is:

		☐ Systolic	☐ Apical	☐ Soft (Gr. 1-2)
☐ Constant	☐ Transmitted	☐ Presystolic	☐ Basal	☐ Mod (Gr. 3-4)
☐ Inconstant	☐ Localized	☐ Diastolic	☐ Other	☐ Loud (Gr. 5-6)
After exercise:	☐ Unchanged	☐ Increased		
	☐ Decreased	☐ Absent		

Show Location Of:

Apex by X
Area of murmur by ◌
Point of greatest intensity by o
Transmission by →



Your impression?

13. Is there on examination any abnormality of the following:

(Circle applicable items and give details.)

	Yes	No
(a) Eyes, ears, nose, mouth and pharynx?	☐	☐
(If vision or hearing markedly impaired, indicate degree and correction.)		
(b) Skin (incl. scars); lymph nodes; blood vessels (incl. varicose veins)?	☐	☐
(c) Nervous system (include reflexes, gait and paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (including scars)?	☐	☐
(f) Genitourinary system (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations and deformities)?	☐	☐
14. Have you any pertinent information not brought out above?	☐	☐

15. Dipstick Urinalysis: MUST BE DONE FOR ALL APPLICANTS

FEMALES:	ALBUMIN	SUGAR
CURRENTLY MENSTRUATING Yes ☐ No ☐		

SEND SPECIMEN TO HOME OFFICE ONLY IF:
a.—Any abnormal dipstick findings.
b.—Blood pressure in excess of 140/90.
c.—History of renal disease, diabetes, or hypertension.

Is specimen being sent to Home Office? ☐ Yes ☐ No

Details of "Yes" answers. (Identify item.)

I certify that I made this examination at _____ A.M. _____ P.M. on the _____ day of _____ year_____.

Examination made at ☐ my office ☐ proposed insured's office ☐ proposed insured's home ☐ other: _____

Examiner's signature: _____ Examiner's address: _____