

Grand Lodge of the Order of the Sons of Hermann In the State of Texas

Name in full _____ Date of birth _____
 Agent's Name _____ Lodge No. _____ Location _____

1. (a) Have you ever had albumin, sugar or casts in your urine, or kidney trouble of any kind? (a) _____
 (b) Has your blood pressure ever been found above or below normal, or have you had any heart trouble? (b) _____
 (c) Have you ever had or been advised to have any surgical operations? (c) _____
 (d) Are you now in good health so far as you know and believe? (d) _____
2. (a) Have you consulted or been treated by any physician or physicians in the last five years? (answer "yes" or "no") _____
 (b) If so, give dates with names and addresses of any such physicians and specify reason for consultation or treatment in each case.

3. What illness, injury or surgical operations have you had? (Except diseases of childhood) (If none, so state)

Illness or Injury	Date	Duration	Name of Medication	Was Operation Performed?	Results	Name and Address Of Physician or Surgeon

4. Family Record	LIVING		DEAD		
	Age	State of Health	Age	Cause of Death	Year
Father					
Mother					
Brothers or Sisters					
No. Living					
No. Dead					

5. Have you EVER smoked cigarettes? Yes ☐ No ☐
- (a) If "Yes":
 1. If a PRESENT smoker, how many cigarettes per day? _____
 2. If a FORMER smoker, how many cigarettes per day? _____
 When did you quit? _____
- (b) If "No":
 Do you use tobacco in any other form? ☐ ☐
 If "Yes," what is used? _____
 What amount per day? _____

6. In the past ten years have you:

- (a) had or been told you had Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex ("ARC"), or AIDS related conditions? ☐ Yes ☐ No
 (b) received advice or treatment in connection with any of the categories mentioned in (a) above? ☐ Yes ☐ No
 (c) tested positive for antibodies to the AIDS (Human T-Cell Lymphotropic, Type III, HTLV-III) virus? ☐ Yes ☐ No
7. Have you ever taken treatments for alcoholic or drug habits? ☐ Yes ☐ No

I hereby declare that all statements and answers as written or printed herein and in Part One of this application are full, complete and true, whether written by my own hand or not, and I agree that they are to be considered the basis for any insurance issued hereon. I hereby authorize any physician or other person who has or may attend me to disclose to the Grand Lodge of the Order of the Sons of Hermann any information thus acquired.

Date _____

Applicant _____
 (Write Name in Full)

Witness _____
 (Medical Examiner)

Part Three — Medical Examiner's Report

1. (a) Age? _____ (a) _____	2. a. Pulse Seated _____	2. b. Is pulse irregular? If so, describe, and where applicable, give the number of irregularities before and after exercise sufficient to increase pulse rate to 100 or more.	
(b) Weight without coat? _____ (b) _____ lbs.			
(c) Height without shoes? _____ (c) _____ ft. _____ in.			
(d) Did you weigh and measure applicant? _____ (d) _____			
(e) Has applicant lost 10 or more pounds in past year? If yes, give amount. _____ (e) _____ lbs.			
3. Blood pressure: Systolic _____ Diastolic _____			
4. Do you find any evidence of past or present disease:	Yes	No	Details
a. of the heart and blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a murmur? If "yes," give location, timing, transmission, quality, intensity, and effect of exercise.	<input type="checkbox"/>	<input type="checkbox"/>	
Any hypertrophy? If "yes," give degree.	<input type="checkbox"/>	<input type="checkbox"/>	
Any arteriosclerosis? If "yes," describe.	<input type="checkbox"/>	<input type="checkbox"/>	
b. of the lungs? Describe and give location.	<input type="checkbox"/>	<input type="checkbox"/>	
c. of any of the abdominal organs. Palpate for any areas of tenderness, masses, or enlargement of the liver or spleen.	<input type="checkbox"/>	<input type="checkbox"/>	
d. of the skin, breasts, ears, middle ears, eyes, throat?	<input type="checkbox"/>	<input type="checkbox"/>	
e. of the brain or nervous system? (Test knee jerks and pupillary reactions.)	<input type="checkbox"/>	<input type="checkbox"/>	
5. a. Is there any enlargement of the thyroid?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Is it symmetrical, asymmetrical, nodular, diffuse?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Are the lymph nodes enlarged? If "yes," describe.	<input type="checkbox"/>	<input type="checkbox"/>	
7. a. Is there a hernia? If "yes," describe.	<input type="checkbox"/>	<input type="checkbox"/>	
b. Was it ever strangulated?	<input type="checkbox"/>	<input type="checkbox"/>	
8. a. Is there any evidence of varicose veins or ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Do they extend above the knees?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Is Applicant lame, maimed, or deformed? Describe.	<input type="checkbox"/>	<input type="checkbox"/>	

URINALYSIS

Mail the specimen to Home Office Reference Laboratory if:

a. SUGAR is found

b. AMOUNT APPLIED FOR IS \$50,000 OR MORE

1. Please record your findings for: Protein? _____ Test Used? _____
 Sugar? _____ Test Used? _____
2. Are you satisfied the specimen is the Applicant's? ☐ Yes ☐ No
3. Have you mailed a specimen to Home Office Reference Laboratory? ☐ Yes ☐ No

BLOOD PROFILE

1. Was a blood sample drawn? ☐ Yes ☐ No Date drawn? _____
2. Has the person examined signed the HORL authorization to draw blood? ☐ Yes ☐ No
3. Were the results forwarded to Home Office Reference Laboratory? ☐ Yes ☐ No
10. (a) Does appearance indicate good health? ☐ Yes ☐ No
- (b) Do you consider applicant a first class risk? ☐ Yes ☐ No If not, explain why: _____

I certify that I have carefully and in private examined _____

this _____ day of _____ 19 _____

Signature of Medical Examiner _____

Address _____