Part 2 of Insurance Application

KNIGHTS OF COLUMBUS
A FRATERNAL BENEFIT SOCIETY
1 COLUMBUS PLAZA
NEW HAVEN, CT 06510-3326
Phone No. (800) 524-3611

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)				Zip 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?

	Yes	No
2. Have you ever received treatment or been told by any physician or other practitioner that such person has or had: (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 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. Have you used tobacco, in any form, within the past year?	☐	☐
6. Have you ever requested or received a pension, benefits or payment because of a bodily injury, sickness or disability?	☐	☐
7. 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?	☐	☐

Details of "Yes" answers. (Identify question. Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.) An additional blank page may be attached, if necessary, to complete "yes" answers.

The statements and answers above and to item 8 on the reverse page 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 made to induce the Knights of Columbus to issue the insurance applied for.

Signed at _____

_____
Signature of Proposed Insured

_____
Date

Witness _____
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 | Zip 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 _____

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

8. 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 DECEASED AGE AT DEATH	IF DECEASED CAUSE OF DEATH
Father				
Mother				
Brothers and Sisters				

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

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?	☐	☐

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: _____