

SPJST

Home Office: Temple, Texas
Medical Examiner:



**Medical Report
For Life Insurance**

_____, M.D.
Print Name

For Medical Examination of:

Address
Date _____, 20____

Print Full Name
Address

FEE: Please indicate fee for this service that you feel is in accord with the usual and customary charges: \$ _____

SPJST

Adult Application for Benefit Certificate and Membership

Part 2

Medical Health History

Every question must be asked by the Medical Examiner and the answers recorded in ink in the Examiner's own handwriting. Please print names and addresses. The Proposed Insured must sign in the Examiner's presence. Examinations must be made in private.

1. Full name of Proposed Insured

Last First Middle 2A. Date of birth _____ 2B. Age _____
Month Day Year

3. For how much insurance are you applying? \$ _____
Face Amount

4. Name and address of family physician _____

5. Date and reason for last visit to a physician _____

6. Are you presently taking any medication? Yes No
☐ ☐

7. Within the past five years, have you:

A. Consulted, been examined by or treated by any physician or practitioner? ☐ ☐

B. Been in a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation or treatment? ☐ ☐

C. Had an X-ray, electrocardiogram, blood study or other diagnostic test? ☐ ☐

D. Had, or been advised to have, a surgical operation? ☐ ☐

8. To the best of your knowledge and belief, within the past ten years, have you had or been told you had:

A. Heart attack, murmur, palpitation, high blood pressure, anemia, varicose veins, phlebitis or any disease or disorder of the heart or circulatory system? ☐ ☐

B. Cancer or tumor of any kind? ☐ ☐

C. Epilepsy, fainting spells, nervous or mental condition, severe headaches, neuritis, paralysis, or any disease or disorder of the brain or nervous system? ☐ ☐

D. Diabetes, goiter or any disease or disorder of the thyroid or other glands? ☐ ☐

E. Tuberculosis, asthma, pleurisy, hay fever, chronic cough, spitting of blood, or any disease or disorder of the lungs or respiratory system? ☐ ☐

Details

Explain fully all "YES" answers to questions 6 through 12. Include diagnoses, treatments, results, dates, durations, and the names and addresses of all doctors and hospitals.

- F. Nephritis, kidney stone, blood in the urine, any disease or disorder of the kidneys or bladder, or any tumor or disease of the prostate, testes, breast, uterus or ovaries, or any complications of pregnancy? ☐ ☐
- G. Any disorder of the lymph nodes? ☐ ☐
- H. Ulcer, indigestion, colitis, gall stones, hernia or any disease or disorder of the stomach, intestines, rectum, appendix, gall bladder or liver? ☐ ☐
- I. Gout, arthritis, rheumatism, rheumatic fever, back trouble, or any disease or disorder of the back, spine, bones, joints or muscles? ☐ ☐
- J. Any disease or disorder of the eyes, ears, nose or throat? ☐ ☐
- K. Any physical deformity or defect? ☐ ☐
- L. Venereal disease? ☐ ☐
- M. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS-related conditions; or have you received advice in connection with AIDS; or have you tested positive for antibodies to the AIDS virus? ☐ ☐
9. In addition to any physicians or hospitals listed above, in the past five years have you:
- A. Consulted any other doctors or practitioners? ☐ ☐
- B. Been treated for any cause(s) or conditions not listed above? ☐ ☐
10. Within the past five years, have you used:
- A. Alcoholic beverages to excess or intoxication? ☐ ☐
- B. Barbituates, sedatives, or tranquilizers habitually? ☐ ☐
- C. L.S.D., marijuana, cocaine or any amphetamine? ☐ ☐
- D. Heroin, morphine or any other narcotic drug? ☐ ☐
11. Are you now pregnant? ☐ ☐
12. Have either of your parents or any of your brothers and sisters ever had heart disease, diabetes or mental illness? ☐ ☐

I hereby agree that the above questions and answers shall be included in Part Two of my pending application for insurance, and also of any subsequent application by me for insurance in SPJST unless I then undergo another medical examination which by its terms is made a part of such application, and of subsequent applications.

And, to the extent permitted by law, I expressly waive all provisions of law prohibiting any physical, hospital official or employee, or any other person who has attended or examined me, or who has been consulted by me, from disclosing any knowledge or information thereby acquired and from testifying with reference thereto. Furthermore, I expressly authorize such persons to make such disclosures.

Signed at _____
City _____ State _____
on _____
Month _____ Day _____ Year _____
Witness _____
Signature of Medical Examiner _____
Signature of Proposed Insured _____

Medical Examiner's Report (not a part of the application)

Part 3

Name of agent requesting examination _____

This form is to be filled out in private.

Make a careful examination of heart and lungs with stethoscope on bared skin. With some histories, findings may have particular significance. Comments regarding relevant findings should be included under "Details" below.

1. Name of Proposed Insured _____

2. Amount of insurance requested in the application
\$ _____

3A. Height (in sock feet) _____ feet _____ inches

3B. Did you measure? ☐ Yes ☐ No

4A. Weight (without jacket) _____ pounds

4B. Did you weigh? ☐ Yes ☐ No

5. Measurements (on bare skin):

A. Chest expanded _____ inches

B. Chest contracted _____ inches

C. Abdomen _____ inches

6. Temperature _____ °F

8. Pulse

Before Exercise

Immediately After

Three Minutes After

Pulse Rate

Irregularities

9. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the:

Yes No

A. Heart or blood vessels? ☐ ☐

(If you find any abnormality of heart size, rhythm or sounds, please complete Question 15.)

B. Brain or nervous system? ☐ ☐

C. Ears, nose, eyes, throat, teeth or gums? ☐ ☐

D. Thyroid or lymph glands? ☐ ☐

E. Lungs? (Describe and give location.) ☐ ☐

F. Breasts? ☐ ☐

G. Stomach or abdominal organs? ☐ ☐

H. Genito-urinary system? ☐ ☐

I. Skin or extremities? ☐ ☐

J. (1) Is there a hernia? (If so, describe it.) ☐ ☐

(2) Was it ever strangulated? ☐ ☐

K. Is there any evidence of varicose veins or ulcers? (If "Yes," indicate under "Details" whether they extend above the knees.) ☐ ☐

10. In connection with the following questions about the Proposed Insured, please explain in the "Details" section any "Yes" answers.

A. Is he/she lame, maimed or deformed? ☐ ☐

B. Does his/her appearance indicate poor health? ☐ ☐

C. Does he/she appear older than stated age? ☐ ☐

D. Do you know of any facts about the health of the Proposed Insured not brought out above? ☐ ☐

7. Blood pressure. (Please record all readings. With history of hypertension, or if first reading is over 135 systolic or over 85 diastolic, take two additional readings at intervals.)

First Reading	Subsequent Readings	Is diastolic at:
Systolic _____	_____	Disappearance of all sound (Phase V)? <input type="checkbox"/>
Diastolic _____	_____	Or change of sound (Phase IV)? <input type="checkbox"/>

15. TO BE COMPLETED IF QUESTION 9A IS ANSWERED "YES":

A. Is there a history of rheumatic fever, chorea, scarlet fever, diphtheria, recurrent tonsillitis, syphilis? ☐ Yes ☐ No

B. Is there a murmur? ☐ Yes ☐ No

Timing

Intensity

Quality

☐ Systolic

☐ Faint

☐ Soft

☐ Presystolic

☐ Moderate

☐ Blowing

☐ Diastolic

☐ Loud

☐ Rough

C. Is the murmur constant or inconstant?

☐ Constant ☐ Inconstant

D. On exercise, does the murmur

☐ Intensify?

☐ Decrease?

☐ Disappear?

E. Show location of murmur.

Apex by ☒

Area of murmur

by outline

Point of greatest

intensity

Transmission ☒

F. Apex beat is _____ cm. to left of midsternal line in the _____ interspace.

G. What is your impression of the murmur?



