(To be filled out by the Medical Examiner only)

MEDICAL EXAMINER'S REPORT

DO NOT WRITE ON THIS CORNER. FOR FILING

12. **Pulse-rate**—seated?---------- **Character** of pulse?

13. **Blood pressure?** (Required where amount applied for is $5,000 or over.)

14. **Age?** years. Does Age given seem correct?

15. Exact **height,** feet . in. Exact **weight,** lbs. Girth of **chest,** at fourth rib, in. Girth of **abdomen** at umbilicus, in.

16. How well do you know applicant?

17. Complexion? Color of hair? Color of eyes?

18. Scars or marks of identification?

19. Is applicant's general appearance **healthy?**

20. Is applicant **deformed, lame** or **maimed?**

21. Is applicant a **Caucasian?** (If not, what is applicant's race?)

22. Has applicant recently **gained** weight? (If so, how much and to what is it due?)

23. Has applicant recently **lost** weight? (If so, how much and to what is it due?)

24. Do you find **any evidence of past or present disease:—**

A. Of **Brain** or **Nervous System?** A. ----

(It is desirable in a doubtful case to test for station (Romberg), general co-ordination and Argyll-Robertson pupil.)

B. Of the **Heart?** B. ----

(By having the applicant bend over rapidly a few times, touching his hands to the floor, a heart murmur not otherwise brought out may be detected.)

C. Of the **Lungs?** C. ----

(Among slender persons with suspected tuberculous tendency or suspicious signs, an observation of the afternoon temperature is desirable.)

D. Of the **Stomach** or any of the **Abdominal Organs?** D. ----

(A history of Appendicitis, Hepatic Colic, Ulcer of Stomach, etc., should lead to careful palpation of the abdomen to determine the presence of tenderness or of adhesions.)

E. **Rheumatism** or **Gout?** (Exclude Muscular Rheumatism.) E. ----

F. Of the **Skin, Middle Ear, Eyes,** or any other part of the body? F. ----

25. A. Does chemical examination of the applicant's **urine** show **albumen** or **sugar?** A.

B. State **specific gravity.** (If abnormal, give your opinion below as to the cause.) B.

C. Give full details of any **genito-urinary ailment?** (Syphilis, Stricture, etc.) C.

26. IF A WOMAN

A. Has she ever had any disease peculiar to her sex? A.

B. Is she now pregnant? B.

C. Have her pregnancies and labors been normal? C.

D. Has she passed the climacteric? D.

27. A. Have you ever seen the applicant under the influence of intoxicants or drugs? A.

B. Do you know or suspect, that the applicant is now, or ever has been, intemperate? B.

(In case of suspected abuse of alcohol examine for tremor of fingers and of tongue.)

28. Do you know anything about the applicant's character or mode of life which unfavorably affects his insurability?

29. Have you reviewed all answers on this and on the reverse side, and are they, so far as you know, full, complete and true?

I CERTIFY that I have **carefully** examined---------- of ----------

in private, and not in the presence of any third person, at ---------- this ---------- day of ---------- 19---- at ---------- o'clock A. M. / P. M. for an insurance of $---------- on the applicant's life, that I have asked each question exactly as set forth on the other side of this sheet and that the applicant's answers thereto are in my handwriting, and are exactly as made by the applicant to me, and that the applicant signed them in my presence.

---------- M. D. ---------- P. O. Address.

TO THE MEDICAL EXAMINER: Any erasures or alterations in your report should be initialed by you. Your report should give the Company a pen picture of the applicant. Any information which for any reason you prefer not to embody in your report should be sent direct to the Company in New York City without delay. If you prefer to do so you may send this report direct to the Company.

ADDITIONAL REMARKS

915-11-12

THIS EXAMINATION MUST BE MADE IN PRIVATE; NO AGENT OR THIRD PERSON BEING PRESENT

(To be filled out by the Medical Examiner only)

ANSWERS MADE TO THE MEDICAL EXAMINER,

In continuation, and forming a part, of my Application for Insurance in the NEW-YORK LIFE INSURANCE CO.

1. A. What is your **occupation?** *(Full details.)*	A.
B. How long have you been engaged in your present occupation?	B.
C. What was your previous occupation?	C.
D. Do you contemplate making **any change,** temporary or permanent, in your **occupation?** *(If so, give full details.)*	D.
2. Do you contemplate **changing** your **residence,** or making a **journey,** or is there any probability that you will do either? *(If so, give full details.)*	
3. In what States have you **lived the last ten years,** and which years in each? *(If outside the U. S., in what countries, and which years in each?)*	
4. A. Have you **now** any connection, direct or indirect, with the **manufacture or sale of wines, spirits or malt liquors?**	A.
B. Have you **ever** had any such connection? *(If so, in either case, give full details.)*	B.
5. A. How frequently, if at all, and in what quantity do you use beer, wine, spirits or other intoxicants?	A.
B. How frequently, if at all, and in what quantity have you used any of them in the past?	B.
C. Have you within the last five years used any of them to excess?	C.
D. Do you now or have you ever used morphine, cocaine, or any other habit forming drug?	D.
6. What is the name of the agent through whom you are making application?	
7. A. Has any Life Insurance Company ever examined you, either on an application for insurance or for any other reason, without issuing a policy? *(If so, state name of Company.)*	A.
B. Has any Life Insurance Company ever issued or offered to issue a policy on your life differing from the one then applied for? *(If so, state name of Company, and give particulars.)*	B.

THE APPLICANT MUST ANSWER THESE QUESTIONS FULLY AND WITH SPECIAL CARE

	"Yes" or "No"	Name of Ailment, Disease or Injury	No. of Attacks	Date	Duration	Severity	Results and, if within five years, name and address of every Physician consulted
8. Have you ever suffered from any ailment or disease of							
A. The Brain or Nervous System?							
B. The Heart or Lungs?							
C. The Stomach or Intestines, Liver, Kidneys or Bladder?							
D. The Skin, Middle Ear or Eyes?							
E. Have you ever had Rheumatism, Gout or Syphilis?							
F. Have you ever raised or spat blood? (If so, give full details.)							
G. Have you ever had any accident or injury?							
H. Have you consulted a physician for any ailment or disease not included in your above answers?							

9. What physician or physicians, if any, not named above, have you consulted or been treated by, within the last five years and for what illness or ailment?

10. **Family Record**	Age if Living	Condition of Health, if not good, give full details	Age at Death	Cause of Death	How Long Ill	Details	Previous Health
Father							
Mother							
Brothers							
Sisters							

NOTE.—In case death was not due to acute disease, give details of last illness and, in case of parents, the year of death.

Ages attained by Grandparents..... Father's Father..... Father's Mother..... Mother's Father..... Mother's Mother.....

11. A. Is any person in your immediate household now ill with consumption?	A.
B. Or has any one of them recently suffered from or died of that disease?	B.

I AGREE, REPRESENT AND DECLARE, on behalf of myself and of every person who shall have or claim any interest in any insurance made hereunder, that I have carefully read each and all of the above answers, that they are each written as made by me, that each of them is full, complete and true, and that to the best of my knowledge and belief I am a proper subject for life insurance. Each and all of my said statements, representations and answers contained in this application are made by me to obtain said insurance, and I understand and agree that they are each material to the risk and that the Company believing them to be true will rely and act upon them.

I expressly waive, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has heretofore attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired.

Dated this..... day of..... 191.....

Witnessed by..... M. D., Medical Examiner

Signature of the person applying for insurance

NOTICE TO MEDICAL EXAMINER. Use only black ink. This examination is to be photographed.