Do you have or have you had any of the following diseases or problems:

Cardiovascular (heart) Disease ___yes ___no
Angina or chest pain ___yes ___no
Congenital heart disease ___yes ___no
Heart attack ___yes ___no
Rheumatic fever ___yes ___no
Heart murmur ___yes ___no
Mitral valve prolapsed ___yes ___no
High or low blood pressure ___yes ___no
Coronary insufficiency or arteriosclerosis ___yes ___no
Pacemaker ___yes ___no

Artificial heart valve ___yes ___no

Artificial joint replacement
(hip, knee, shoulder) ___yes ___no

Hepatitis, jaundice or liver disease ___yes ___no
Immune System Disorders: HIV+ / AIDS / ARC ___yes ___no
Venereal Diseases ___yes ___no
Cancer ___yes ___no
Radiation and/or chemo therapy ___yes ___no

Lung Disease; Asthma, Respiratory disease,
Breathing disorders, Emphysema ___yes ___no

Digestive system disease (ulcers, colitis, other) ___yes ___no
Diabetes ___yes ___no
Epilepsy, seizure disorder or fainting spells ___yes ___no
Blood Disorders (anemia, Hemophilia, other) ___yes ___no
Circulatory problems ___ yes ___no
Kidney or bladder disease ___yes ___no
Dialysis ___yes ___no

Allergies ___yes ___no
Sinus problems ___yes ___no
Hives or skin rash ___yes ___no

Arthritis or inflammatory rheumatism ___yes ___no
Eye related problems
(Glaucoma, lens implants, other) ___yes ___no

Do you have an allergy to any
prescribed or OTC medications? ___yes ___no
If so, to what? ____
Other allergies? ____

Do you have any condition, disease or problem not listed
that you think we should know about? ____

Women: Are you now or are you planning to become pregnant? ___yes ___no
Do you have problems associated with your menstrual cycle? ___yes ___no
Are you taking hormone replacement or birth control pills? ___yes ___no

To the best of my knowledge, all the above answers are true and correct. If I ever have any changes in my health status or any medications that I am taking I will inform you or your staff as soon as possible.

Signature x_______________________________________ Date______________