MEDICAL HISTORY QUESTIONNAIRE

(Please Print)

Name _____ **SS No.** _____ **DOB** _____
Last First MI MM/DD/YYYY

Address _____ **Home Phone:** _____
Street City State Zip

Occupation _____ **Department/School** _____

Answer ALL of the following questions. Check Yes or No. If Yes, explain below.

	Have you ever had or DO YOU NOW HAVE?						
		YES	NO			YES	NO
1.	CARDIAC DISEASE			21.	AMPUTATED FOOT, LEG, ARM OR HAND		
2.	ARTHRITIS, BACK OR JOINT PAIN			22.	RESIDUAL DISABILITY FROM POLIOMYELITIS		
3.	BROKEN BONES OR BONE INJURY			23.	CEREBRAL PALSY		
4.	MAJOR OR CHRONIC ILLNESS			24.	MULTIPLE SCLEROSIS		
5.	OPERATIONS			25.	PARKINSON'S DISEASE		
6.	EYE TROUBLE			26.	CEREBRAL VASCULAR ACCIDENT		
7.	DEAFNESS OR EAR TROUBLE			27.	TUBERCULOSIS OR CHEST DISEASE		
8.	FREQUENT COLDS OR PERSISTENT COUGH			28.	SILICOSIS		
9.	PNEUMONIA OR PLEURISY			29.	DIABETES OR THYROID DISEASE		
10.	HEART DISEASE			30.	CHEST PAIN OR ANGINA		
11.	HIGH BLOOD PRESSURE			31.	EPILEPSY OR SEIZURES		
12.	VARICOSE VEINS OR SWELLING OF ANKLES			32.	CIRCULATORY DISEASE OR PHLEBITIS		
13.	ALLERGY, HAY FEVER OR ASTHMA			33.	HEMOPHILIA		
14.	CHRONIC OSTEOMYELITIS			34.	ANKYLOSIS OF JOINTS		
15.	HYPERINSULINISM			35.	MUSCULAR DYSTROPHY		
16.	ARTERIOSCLEROSIS			36.	HEAVY METAL POISONING		
17.	IONIZING RADIATION INJURY			37.	COMPRESSED AIR SEQUELAE		
18.	RUPTURED INTERVERTEBRAL DISC			38.	HODGKINS DISEASE		
19.	BRAIN DAMAGE			39.	LOSS OF SIGHT OF ONE OR BOTH EYES OR A PARTIAL LOSS OF UNCORRECTED VISION OF MORE THAN SEVENTY-FIVE PERCENT BILATERAL		
20.	PSYCHONEUROTIC DISABILITY FOLLOWING TREATMENT IN A RECOGNIZED MEDICAL OR MENTAL INSTITUTION						

Explanation of Items checked YES. Identify by number. If additional space is needed, use reverse side.

CERTIFICATION

I, the undersigned, do hereby certify that to the best of my knowledge, the answers I have provided to the questions above are true, that I have no physical defects as stated, and that I will openly discuss my physical condition with a designated physician if necessary.

Signed _____ Date _____