Have you had in the past or currently have any of the following medical conditions? Mark all that apply:

☐	AIDS/HIV	☐	Anemia	☐	Arthritis
☐	Artificial Heart Valves	☐	Artificial Joints	☐	Asthma
☐	Back Problems	☐	Bleeding Abnormally	☐	Blood Disease
☐	Cancer	☐	Chemical Dependency	☐	Chemotherapy
☐	Circulatory Problems	☐	Congenital Heart Lesions	☐	Cortisone Treatment
☐	Cough, Persistent or Bloody	☐	Diabetes	☐	Emphysema
☐	Epilepsy	☐	Fainting / Dizziness	☐	Glaucoma
☐	Headaches	☐	Heart Murmur	☐	Heart Problems
☐	Hepatitis Type _____	☐	Herpes	☐	High Blood Pressure
☐	Jaundice	☐	Jaw Pain	☐	Kidney Disease
☐	Liver Disease	☐	Low Blood Pressure	☐	Mitral Valve Prolapse
☐	Nervous Problems	☐	Pacemaker	☐	Psychiatric Problems
☐	Radiation Treatments	☐	Respiratory Disease	☐	Rheumatic Fever
☐	Scarlet Fever	☐	Shortness of Breath	☐	Sinus Trouble
☐	Skin Rash	☐	Special Diet	☐	Stroke
☐	Swollen Feet / Ankles	☐	Swollen Neck Glands	☐	Thyroid Problems
☐	Tonsillitis	☐	Tuberculosis	☐	Tumor / Growth on Head
☐	Ulcer	☐	Venereal Disease	☐	Weight Loss, Unexplained

Notes: