

# HEALTH HISTORY FORM

Applicant's Name \_\_\_\_\_  
*Last Name*
*First Name*
*Middle*
*Preferred*

School/Program/Position Applying For: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street*
*City*
*Prov./State*
*Postal (Zip) Code*
*Country*

Phone numbers: \_\_\_\_\_ Email: \_\_\_\_\_  
*Daytime*
*Evening*

**MEDICAL INSURANCE: It is a mandatory requirement for all applicants to have medical insurance coverage during your time with us.**

Name of Insurer: \_\_\_\_\_ Medical Insurance Coverage: \_\_\_\_\_

## PERSONAL HEALTH HISTORY

Please check all that apply. Comment in the space provided below for any checked "yes".

- |  |                          |                             |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
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| <table border="0" style="width: 100%;"> <tr><td style="width: 50px;">Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Skin condition</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Eye trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ear trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Head injury</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Recurrent headaches</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fainting spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Depression (specify)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Weakness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Paralysis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Insomnia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shortness of breath, Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hay fever</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Motion sickness</td></tr> </table> | Yes                      | No                          |  | <input type="checkbox"/> | <input type="checkbox"/> | Skin condition | <input type="checkbox"/> | <input type="checkbox"/> | Eye trouble | <input type="checkbox"/> | <input type="checkbox"/> | Ear trouble | <input type="checkbox"/> | <input type="checkbox"/> | Head injury | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent headaches | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells | <input type="checkbox"/> | <input type="checkbox"/> | Depression (specify) | <input type="checkbox"/> | <input type="checkbox"/> | Weakness | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath, Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever | <input type="checkbox"/> | <input type="checkbox"/> | Motion sickness | <table border="0" style="width: 100%;"> <tr><td style="width: 50px;">Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>High blood pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Low blood pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Rheumatism/Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Back problems/injury</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dislocation of joints</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Broken bones (specify)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ulcer (specify)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Gall bladder problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Surgery (See next page)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Jaundice</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hepatitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Recurrent diarrhea</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Constipation</td></tr> </table> | Yes | No |  | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism/Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Back problems/injury | <input type="checkbox"/> | <input type="checkbox"/> | Dislocation of joints | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones (specify) | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer (specify) | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder problems | <input type="checkbox"/> | <input type="checkbox"/> | Surgery (See next page) | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <table border="0" style="width: 100%;"> <tr><td style="width: 50px;">Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer (specify)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Eating disorders (specify)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies (specify)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sleep walking</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Nose bleeds</td></tr> </table> <p><b>FEMALES ONLY</b></p> <table border="0" style="width: 100%;"> <tr><td style="width: 50px;">Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Irregular periods</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Severe cramps</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Excessive flow</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Are you pregnant?</td></tr> </table> | Yes | No |  | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Cancer (specify) | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorders (specify) | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (specify) | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Sleep walking | <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds | Yes | No |  | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods | <input type="checkbox"/> | <input type="checkbox"/> | Severe cramps | <input type="checkbox"/> | <input type="checkbox"/> | Excessive flow | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| Yes  | No                       |                             |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Skin condition              |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Eye trouble                 |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Ear trouble                 |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Head injury                 |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Recurrent headaches         |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Epilepsy                    |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Fainting spells             |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Depression (specify)        |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Weakness                    |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Paralysis                   |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Insomnia                    |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Shortness of breath, Asthma |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Hay fever                   |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Motion sickness             |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| Yes  | No                       |                             |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Heart trouble               |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | High blood pressure         |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Low blood pressure          |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Rheumatism/Arthritis        |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Back problems/injury        |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Dislocation of joints       |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Broken bones (specify)      |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Ulcer (specify)             |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Gall bladder problems       |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Surgery (See next page)     |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Jaundice                    |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Hepatitis                   |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Recurrent diarrhea          |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Constipation                |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| Yes  | No                       |                             |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Kidney disease              |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Anemia                      |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Cancer (specify)            |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Eating disorders (specify)  |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Allergies (specify)         |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Diabetes                    |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Sleep walking               |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Nose bleeds                 |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| Yes  | No                       |                             |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Irregular periods           |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Severe cramps               |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Excessive flow              |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Are you pregnant?           |  |                          |                          |                |                          |                          |             |                          |                          |             |                          |                          |             |                          |                          |                     |                          |                          |          |                          |                          |                 |                          |                          |                      |                          |                          |          |                          |                          |           |                          |                          |          |                          |                          |                             |                          |                          |           |                          |                          |                 |  |     |    |  |                          |                          |               |                          |                          |                     |                          |                          |                    |                          |                          |                      |                          |                          |                      |                          |                          |                       |                          |                          |                        |                          |                          |                 |                          |                          |                       |                          |                          |                         |                          |                          |          |                          |                          |           |                          |                          |                    |                          |                          |              |  |     |    |  |                          |                          |                |                          |                          |        |                          |                          |                  |                          |                          |                            |                          |                          |                     |                          |                          |          |                          |                          |               |                          |                          |             |     |    |  |                          |                          |                   |                          |                          |               |                          |                          |                |                          |                          |                   |

Please comment on all conditions above indicated "yes": \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other illness or conditions not listed above: \_\_\_\_\_

Are you at present under the doctor's care for any condition?  No  Yes (specify) \_\_\_\_\_

Are you taking any medication at this time?  No  Yes (specify) \_\_\_\_\_

Are you allergic to any drugs?  No  Yes (specify) \_\_\_\_\_

Do you have any food allergies?  No  Yes (specify) \_\_\_\_\_

Are you allergic to bee or wasp stings?  No  Yes (specify) \_\_\_\_\_

Do you have any special diet needs?  No  Yes (specify) \_\_\_\_\_

Do you wear contact lenses or glasses?  No  Yes (specify) \_\_\_\_\_

Do you have a history of emotional instability or psychiatric treatment?  No  Yes (specify) \_\_\_\_\_

Do you now or have you ever received any compensation for disability from any source?  No  Yes (specify) \_\_\_\_\_

Do you have any physical impairments, handicaps or conditions which could affect you during physical activity or that require special attention?  No  Yes (specify) \_\_\_\_\_

Please rate your overall physical health:  Excellent/Strong  Above Average  Average  Below Average  Poor/Weak

Note: it is unlawful for YWAM staff or volunteers to administer or give out any kind of drugs, either prescription or over the counter. Therefore, if you require any medication to treat a chronic health condition, allergy, etc., please bring it with you (i.e. Tylenol, Ventilin, Ibuprofen, hay fever medication, etc.) If you are allergic to bee or wasp stings (or suspect you may be) you MUST bring your own epipen with you.

## COMMUNICABLE DISEASES

Have you ever been exposed to or do you carry any contagious diseases or infections?  No  Yes (specify) \_\_\_\_\_

Have you ever had any of the following?

Yes No

- Chickenpox  
  Scarlet Fever  
  Mumps

Yes No

- Measles (specify) \_\_\_\_\_  
  Meningitis \_\_\_\_\_  
  Other (specify) \_\_\_\_\_

Other (specify) \_\_\_\_\_

Have you ever been tested for the following?

HIV or AIDS  No  Yes  
Tuberculosis (TB)  No  Yes

If Yes: Results  Negative  Positive  
If Yes: Results  Negative  Positive

## SURGICAL HISTORY

Please list your surgical history:

DATE PERFORMED (month/year)	TYPE OF SURGERY	OUTCOME/LONG-TERM EFFECTS

## OTHER INFORMATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Type \_\_\_\_\_

What time do you typically go to bed at? \_\_\_\_\_ What time do you typically wake up? \_\_\_\_\_

Would you say you are more of a "morning" or a "night" person? \_\_\_\_\_

What do you do for exercise? \_\_\_\_\_ How often? \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Full Name: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Address \_\_\_\_\_  
*Street / P.O. Box City Prov./State*

*Postal (Zip) Code*

*Country*

*Daytime Phone*

*Evening Phone*

*Email*

I certify that all information in this application is complete and accurate: \_\_\_\_\_ Date: \_\_\_\_\_  
*Signature Day/Month/Year*

If the applicant is under 18 years of age, Parent/Guardian signature is required: \_\_\_\_\_ Date: \_\_\_\_\_  
*Signature Day/Month/Year*



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