HEALTH QUESTIONS

1 Has there been any changes in your general health within the last year?..... Yes No

2 When was your last physical examination? _____ / _____ / _____

3 Are you being seen regularly by a physician for a disease or illness?..... Yes No

4 Have you had any serious illness, operation, or been hospitalized in the last 5 years?..... Yes No

5 Are you taking any medicine(s), including nonprescription medicine?..... Yes No

6 Have you now, or in the past, ever had any of the following conditions?

- a) Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease?..... Yes No
- b) Cardiovascular disease (heart trouble, heart attack, angina, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
  - 1 Do you ever have chest pain?..... Yes No
  - 2 Are you ever short of breath after mild exercise or when lying down?..... Yes No
  - 3 Do your ankles swell?..... Yes No
  - 4 Do you have a heart defect or heart murmur?..... Yes No
  - 5 Do you have a cardiac pacemaker?..... Yes No
- c) Sinus Trouble..... Yes No
- d) Asthma or hay fever..... Yes No
- e) Fainting spells or seizures..... Yes No
- f) Persistent diarrhea or recent weight loss..... Yes No
- g) Diabetes or a family history of diabetes..... Yes No
- h) Hepatitis, jaundice, or liver disease..... Yes No
- i) AIDS or HIV infection..... Yes No
- j) Thyroid problems..... Yes No
- k) Respiratory problems, emphysema, bronchitis, etc..... Yes No
- l) Arthritis or painful swollen joints..... Yes No
- m) Stomach ulcer or hyperacidity..... Yes No
- n) Kidney trouble..... Yes No
- o) Tuberculosis..... Yes No
- p) Persistent cough or a cough that produces blood..... Yes No
- q) Persistent swollen glands in neck..... Yes No
- r) Low blood pressure or high blood pressure..... Yes No
- s) Sexually transmitted disease, such as gonorrhea, syphilis, or herpes..... Yes No
- t) Epilepsy or other neurological disease..... Yes No
- u) Emotional Problems..... Yes No
- v) Cancer..... Yes No
- w) Have you had abnormal or excessive bleeding?..... Yes No
- x) Have you ever required a blood transfusion?..... Yes No
- y) Do you have any blood disorders, such as anemia, leukemia, or sickle-cell disease?..... Yes No
- z) Have you ever had any treatment for a tumor or growth?..... Yes No
- aa) Artificial joint replacement..... Yes No
- bb) Mitral value prolapse..... Yes No

7 Are you allergic or have you had a reaction to:

- a) Penicillin..... Yes No
- b) Sulfa Drugs..... Yes No
- c) Barbiturates, sedatives, or sleeping pills..... Yes No
- d) Aspirin..... Yes No
- e) Iodine..... Yes No
- f) Codeine..... Yes No
- g) Latex Products..... Yes No
- h) Other..... Yes No

8 Do you smoke or use tobacco in any form?..... Yes No