### Ability & Disability
- Hearing Impaired
- Learning Disability
- Mobility/Wheel Chair
- Non-correctable Visual Impairment
- My primary language (if not English) ________________

### Blood Disorders
- Bleeding Disorder
- Blood Clots/Phlebitis

### Bone and Joint Problems
- Arthritis
- Back Pain, chronic
- Lupus

### Cancer
- Leukemia or Lymphoma
- Melanoma

### Cancer – continued:
- Testicular Cancer
- Diabetes
- Thyroid Disorder

### Eye/Vision
- Glaucoma
- Wear glasses or contacts

### Gastrointestinal/Stomach
- Inflammatory Bowel Disease

### Heart/Cardiovascular
- Heart Murmur
- High Blood Pressure
- High Cholesterol
- Passed out with exercise
- Stroke

### Infections
- Hepatitis B or C

### Infections - continued
- Immunocompromising Illness
- Mononucleosis
- Sexually Transmitted Infection

### General Health
- Use Tobacco
- Drink Alcohol
- Use recreational drugs
- Use caffeine or energy drinks

### Mental Health
- Alcoholism/Drug Abuse
- Anxiety Disorder
- Bipolar Disorder (Manic/depression)
- Depression

### Mental Health – continued:
- Eating Disorder
- Neurological (Brain)
- Attention Deficit
- Migraine Headaches
- Seizure

### Respiratory/Breathing
- Asthma (including exercise-induced asthma)
- Cystic Fibrosis

### Urinary
- Kidney Stones
- Polycystic Kidney Disease
- Urinary Infections (Cystitis)

### Height

### Weight

### Medical History

**Explain any items you have checked in the comment section below. Include any additional significant illnesses.**

### Medication
- List all medications you take regularly, including birth control pills, non-prescription drugs and herbal preparations.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage of Medication</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### Allergies
- List any allergic or other significant reactions to medication.

<table>
<thead>
<tr>
<th>Medication causing Allergy</th>
<th>Type of Reaction</th>
<th>Approximate Date of Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Surgery, significant injuries, hospital stays
- Describe and include dates.

<table>
<thead>
<tr>
<th>Description</th>
<th>Approximate Date</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### Family History
- Complete the fields to the best of your knowledge for family members. Include heart disease, high cholesterol, diabetes, high blood pressure, tuberculosis, stroke, alcoholism, depression, other mental illness, and cancer (specify type).
- Are you adopted?  Yes ☐ No ☐

1. Father: Year of Birth: __________ Occupation: ___________________ Age at Death(if deceased): ____
   - Medical Problems
   - Approximate Onset Date
   - Comment

2. Mother: Year of Birth: __________ Occupation: ___________________ Age at Death(if deceased): ____
   - Medical Problems
   - Approximate Onset Date
   - Comment

   - Age at Death(if deceased): __________
   - Cause of Death (if deceased):
   - Medical Problems
   - Approximate Onset Date
   - Comment