Check the appropriate box for the disorders you have or have had in the past.

Infectious Diseases	**Yes**	**No**	**Respiratory System**	**Yes**	**No**
Pneumonia	☐	☐	Sinus Infection	☐	☐
Frequent sore throats	☐	☐	Asthma	☐	☐
Dysentery (Chronic)	☐	☐	Hay fever	☐	☐
Infantile Paralysis (Polio)	☐	☐	Bronchitis	☐	☐
Syphilis	☐	☐	Pleurisy	☐	☐
Gonorrhea	☐	☐	Tuberculosis	☐	☐
Skin diseases or eczema	☐	☐	Chronic cough	☐	☐
Fevers	☐	☐	Chronic hoarseness	☐	☐
Recurrent Chills	☐	☐	Coughing up blood	☐	☐
Lymph node enlargement	☐	☐	Tobacco use	☐	☐
Heart and Blood Vessels	**Yes**	**No**	**Nervous System**	**Yes**	**No**
High or low blood pressure	☐	☐	Epileptic or other fits	☐	☐
Heart disease	☐	☐	Meningitis	☐	☐
Pain in chest	☐	☐	Mental or nervous diseases (family)	☐	☐
Rheumatic fever	☐	☐	Mental or nervous diseases (self)	☐	☐
Heart murmur	☐	☐	Dizzy spells	☐	☐
Palpitations	☐	☐	Fainting spells	☐	☐
Shortness of breath	☐	☐	Visual problems	☐	☐
Swollen ankles	☐	☐	Deafness	☐	☐
Anemia or blood disease	☐	☐	Ringing ears, hearing difficulty	☐	☐
Coagulation disorder	☐	☐	Paralysis	☐	☐
Elevated cholesterol	☐	☐	Weakness of limbs	☐	☐
			Numbness	☐	☐
Digestive System	**Yes**	**No**	**Miscellaneous**	**Yes**	**No**
Ulcers	☐	☐	Cancer	☐	☐
Jaundice	☐	☐	Lymphoma or Other Blood Disease	☐	☐
Hepatitis	☐	☐	Diabetes or sugar disease (family)	☐	☐
Recurrent diarrhea	☐	☐	Diabetes or sugar disease (self)	☐	☐
Bloody stools	☐	☐	Thyroid disease	☐	☐
Marked over or underweight	☐	☐	Foot problems	☐	☐
Recent weight loss	☐	☐	Back pain	☐	☐
Gall bladder disease	☐	☐	Joint pain	☐	☐
Hernia (rupture)	☐	☐	Allergy to any food, medicine or injection	☐	☐
Genitourinary System	**Yes**	**No**	Blood transfusions	☐	☐
Kidney disease	☐	☐	Arthritis	☐	☐
Kidney stones	☐	☐	Daily use of nicotine (past 5 years)	☐	☐
Prostate disease	☐	☐	Have you ever been a habitual user of any habit forming drugs or received treatment for alcoholism or drug abuse?	☐	☐
Bladder disease	☐	☐	Have you ever had any illnesses (mental or physical) or accidents other than those mentioned?	☐	☐
Blood in urine	☐	☐			
Pain in passing urine	☐	☐			
Urinary tract infection	☐	☐			

I hereby declare that my answers to the above questions are full and true.

_____
(Full signature of applicant)

Signed at in my presence, this day of , .

_____
(Physician)