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ILLNESS AND MEDICAL PROBLEMS

Please mark with an "X" any of the following illnesses and medical problems you have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year time it occurred.

ILLNESS	X	YEAR	N/A
Eye or Eyelid infection			
Glaucoma			
Other Eye Problems			
Ear Condition			
Deafness or Decreased Hearing			
Thyroid Problem			
Strep Throat			
Bronchitis			
Emphysema			
Pneumonia			
Allergies, Asthma, or Hay Fever			
Nose Bleeds			
Tuberculosis			
Other Lung Problems			
Difficulty Breathing			
High Blood Pressure			
High Cholesterol			
Atherosclerosis (Bleeding of The Arteries			
Heart Attack			
Chest Pain			
Irregular Heartbeat			
Heart Murmur			
Other Heart Conditions			
Stomach/Digestional Ulcer			
Nausea			
Vomiting			
Weight Loss			
Weight Gain			
Difficulty Swallowing			
Diverticulosis			
Clotting			
Other Bowl Problems			
Blood in Stool			
Diarrhea			
Hemorrhoids			
Early Fatigue			
Hepatitis			
Liver Problems			
Gallbladder Problems			
Herpes			
Kidney or Bladder Disease			
Prostate Problems (Males Only)			
Ovarian Problems (Female Only)			
Late Menstrual Periods			
Last Pregnancy			
Menstrual Flow Pattern			
Venereal Disease			
Genital Herpes			
Breast Disease			
Nipple Disease			
Headaches			
ILLNESS	X	YEAR	N/A
Head Injury			
Strokes			
Cardiovascular Seizures			
Blood Clots			
Mental Problem			
Arteries			
Gout			

Cancer or Tumor			
Bleeding Tendency			
Diabetes			
Measles/Rubella			
Germen Measles/Rubella			
Polio			
Scarlet Fever			
Chicken Pox			
Monoecious			
Psoriasis			
Skin Rash			
Open Wounds			
Infection			
Muscle Stiffness			
Muscle Weakness			
Muscle Pain			
Bone Fracture			
Bone Stiffness			
Other			

Signature___________________________