Ongoing Medical Problems – CHECK WHAT APPLIES **Describe your problem**

Headaches	Yes ☐ No ☐		____________________
Eyes/Vision	Yes ☐ No ☐		____________________
Do you wear contacts/glasses?	Yes ☐ No ☐	Last Exam:	____________________
Ears, Nose, Throat	Yes ☐ No ☐		____________________
Lungs, Breathing	Yes ☐ No ☐		____________________
Heart Problems	Yes ☐ No ☐		____________________
Digestion	Yes ☐ No ☐		____________________
Bowel Problems	Yes ☐ No ☐		____________________
Bladder Problems	Yes ☐ No ☐		____________________
Diabetes	Yes ☐ No ☐		____________________
High Blood Pressure	Yes ☐ No ☐		____________________
Bleeding Problems	Yes ☐ No ☐		____________________
Balance Problems (Dizziness)	Yes ☐ No ☐		____________________
Numbness/Tingling	Yes ☐ No ☐		____________________
Blackout/Fainting	Yes ☐ No ☐		____________________
Anxiety/Depression	Yes ☐ No ☐		____________________
AIDS/HIV	Yes ☐ No ☐		____________________
Cancer	Yes ☐ No ☐		____________________
Arthritis	Yes ☐ No ☐		____________________
Polio	Yes ☐ No ☐		____________________
Tuberculosis	Yes ☐ No ☐		____________________
Epilepsy (Seizures)	Yes ☐ No ☐		____________________