



## Applicant's Medical History

Member # \_\_\_\_\_ Name: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ City, St, Zip: \_\_\_\_\_

**YES RESPONSES AND ANY MEDICATIONS YOU ARE TAKING, should be explained below and submitted with a physical exam.**

Conditions	Yes	No
<b>Diabetes: Insulin Injected</b>		
<b>Epilepsy or Seizures</b>		
<b>Heart Trouble</b>		
<b>Coronary Artery Disease or Angina Valve Disease</b>		
<b>Abnormal Cardiac Rhythms Left Bundle Branch Block</b>		
<b>High Blood Pressure</b>		
<b>Any Drug, Narcotic, or Alcohol problems</b>		
<b>Amputation/Physical disability</b>		
<b>Anemia, or other blood disease including abnormal bleeding</b>		
<b>Cancer (Last 5 Years)</b>		

Conditions	Yes	No
<b>Psychiatric/Mental Health Problems</b>		
<b>Dizziness or Fainting spells</b>		
<b>Operation (s) involving eyes, Brain, Heart, Nerves, Blood Vessels, or Bones</b>		
<b>Previous waiver (s) for medical condition (s) List:</b>		
<b>Previous Denial (s) due to medical reason (s) List:</b>		
<b>Admission to the hospital in the past 12 months. Why?</b>		
<b>Allergy (s) to medications. List:</b>		
<b>Unconsciousness for any reason</b>		
<b>Eye trouble (except glasses)</b>		
<b>Illness (s) not mentioned above, List:</b>		

Blood Type (if known): \_\_\_\_\_ Date of last Tetanus: \_\_\_\_\_  
 List Medications:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**This is to certify that these statements are true and accurate.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**Please explain in detail all Yes responses and any medication listed on the Medical History form:**

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Illnesses not previously listed elsewhere: \_\_\_\_\_

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Comments: \_\_\_\_\_

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**This is to certify that these statements are true and accurate.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_