

To be completed by each family member. If your medical information will not fit on this questionnaire, please attach an additional sheet.

A. Applicant Information

First Name _____ Last Name _____ Initial _____

Physician Name _____ Physician Phone (_____) _____

B. Medical Conditions

Have you ever suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following:

Cardiovascular/Heart Yes No *If "Yes", please indicate the condition(s) below.*

Arrhythmia Chest Pain/Angina Congestive Heart Failure Arterial Bypass Aneurysm
 Atrial Fibrillation Heart Attack Arteriosclerosis/Angioplasty Heart Murmur Other

If Other, please specify the condition. _____

What was your earliest date of diagnosis for any of the above Cardiovascular/Heart condition(s)? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your Cardiovascular/Heart condition(s)?

Cerebrovascular/Stroke Yes No *If "Yes", please indicate the condition(s) below.*

Cerebrovascular Accident (CVA) Transient Ischemic Attack (TIA) Neurological Disorder Other

If Other, please specify the condition. _____

What was your earliest date of diagnosis for any of the above Cerebrovascular/Stroke condition(s)? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your Cerebrovascular/Stroke condition(s)?

Respiratory/Lung Yes No *If "Yes", please indicate the condition(s) or treatment(s) below.*

Chronic Obstructive Pulmonary Disease (COPD) Asthmatic Bronchitis/Bronchial Asthma Emphysema Other
 Chronic Bronchitis Home Oxygen Prednisone

If Other, please specify the condition. _____

What was the earliest date of diagnosis for any of the above Respiratory/Lung condition(s)? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your Respiratory/Lung condition(s)?

Gastrointestinal/Liver/Kidney/Urinary Yes No *If "Yes", please indicate the condition(s) below.*

Kidney Disorder Liver Disease Diverticulitis Stomach/Bowel disorder Other
 Intestinal Bleeding Peptic Ulcer Spleen/Pancreas disorder Urinary disorder

If Other, please specify the condition. _____

What was the earliest date of diagnosis for any of the above Gastrointestinal/Liver/Kidney/Urinary condition(s)? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your Gastrointestinal/Liver/Kidney/Urinary condition(s)?

Cancer Yes No *If "Yes", please specify below.*

Cancer is eliminated Radiation Treatment Chemotherapy No treatment/Other treatment

Please also specify any medications and the site and stage of the Cancer. _____

What was the date of diagnosis for your Cancer? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your Cancer?
