

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 _____

Specialist Name _____ Specialist 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 Other

Atrial fibrillation Heart attack Arteriosclerosis/angioplasty

Heart murmur Aneurysm Arterial bypass

If other, please specify the condition. _____

What was the date of diagnosis for your 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?

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 the date of diagnosis for your 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?

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

Chronic obstructive pulmonary disease (COPD) Asthmatic bronchitis/bronchial asthma Emphysema Prednisone

Chronic bronchitis Liver disease Home oxygen Other

If other, please specify the condition. _____

What was the date of diagnosis for your 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?

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

Kidney disorder Liver disease Diverticulitis

Intestinal bleeding Peptic ulcer Spleen/pancreas disorder

Stomach/bowel disorder Urinary disorder Other

If other, please specify the condition. _____

What was the date of diagnosis for your gastro-intestinal/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 gastro-intestinal/liver/kidney/urinary condition?

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

Cancer is eliminated Radiation treatment Chemotherapy No treatment/other treatment

If other, please specify the condition. _____

What was the date of diagnosis for your 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?
