HEALTH HISTORY - STATEMENT BY APPLICANT

1. Name (Last) (First) (Initial) 2. Sex 3. Date

4. Family History

State of Parent	Age	Health	If dead, give cause and age at death
Father			
Mother			

Name of your Family Physician: ___________________

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5. Have your parents ever had: (yes/no)

Parent	TB	Diabetes	Cancer	High Blood Pressure
Father				
Mother				

	Disease	Heart Illness	Mental
Father			
Mother			

6. Have you ever had, or have you now: (check every item or write “don’t know”)

Item	Yes	No	Item	Yes	No
Asthma			Neuritis		
Bone or joint deformity			Numbness, weakness, fatigue		
Breath shortness			Palpitations, pounding heart		
Broken bones or bone disease			Piles or rectal disease		
Cancer, cyst, growth or tumor			Rash or hives		
Chest paint or pressure			Rheumatism or arthritis		
Chills, fever, night sweats			Rheumatic fever		
Chronic cough or cold			Rupture		
Convulsions			Scarlet fever		
Coughing or vomiting blood			Shoulder, arm, hand pains		
Diabetes			Swelling ankles or feet		
Dizziness			Swollen or painful joints		
Ear, nose, throat trouble			Trick or locked knee		
Epilepsy			Tuberculosis		
Foot trouble			Ulcers		
Fainting			Varicose veins		
Gall stones			Worry or depression		
Glaucoma or cataracts					
Headaches (frequent or severe)			7. FOLLOWING FOR WOMEN ONLY		
Hearing difficulties			Been pregnant		
High blood pressure			Had vaginal discharge		
Hoarseness			Treated for female disorders		
Indigestion (frequent or severe)			Had painful menstruation		
Insomnia			Complete the following:		
Kidney stones or blood in urine			Number of pregnancies		
Liver disease or jaundice			Interval between periods		
Loss of appetite (nausea)			Duration of periods		
Malaria			Date of last period		

8. Do you now or have you had any illness, injury, examination or treatment by a physician or practitioner within the past 5 years?

HEALTH HISTORY - STATEMENT BY APPLICANT (cont'd.)

9. If the answer is "yes" to No. 8, please give the name and address of attending physician or practitioner; and fill in the following:

Name of Ailment	Period Covered	Degree of Recovery

10. Have you ever had any back trouble (injury, illness, or pain)	Yes	No	If "yes" give details
11. Is an operation contemplated or has one been recommended by a physician?			
12. Have you ever been a patient in a hospital or sanitorium?			
13. Have you ever been declined or postponed for life or health insurance?			
14. Do you have any physical complaint, disability or defects at the present time?			
15. Have you ever been injured while at work?			If "yes," fill in the following:

Date of Accident	Name of Employer	Type of Injury

16. Do you have a service-connected disability? Yes No

17. Have you ever been disqualified for duty in or discharged from the Armed Services for medical reasons? If so, please provide general details below.

Yes _____ No _____

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18. Are you taking any medicines or drugs now? Yes No

I understand this will become a part of my permanent medical record.

____
Signature

____
Date