Applicant's Medical History

Name Age Date of Birth Sex

Street Address City/State/Zip Single Married

Region of Record Occupation Widowed Divorced

Your Personal Physician Address

Examining Physician (today) Address

A. Have you been treated for, have you ever had, or have you now any of the following? (For each "yes" checked, describe or explain below or on separate sheet.)

YES		NO
_____	1. Frequent or severe headaches	_____
_____	2. Dizziness or fainting spells	_____
_____	3. Unconsciousness for any reason	_____
_____	4. Eye trouble, except glasses	_____
_____	5. Hay fever	_____
_____	6. Asthma	_____
_____	7. Allergy to medications or other drugs in addition to hay fever and asthma	_____
_____	8. Diabetes--insulin and how much	_____
_____	9. Heart trouble	_____
_____	10. High or low blood pressure	_____
_____	11. Anemia or other blood diseases, including abnormal bleeding	_____
_____	12. Stomach trouble	_____
_____	13. Kidney stone or blood in urine	_____
_____	14. Sugar or albumin in urine	_____
_____	15. Epilepsy or fits	_____
_____	16. Nervous trouble of any sort	_____
_____	17. Any mental trouble	_____
_____	18. Any drug or narcotic habit	_____
_____	19. Excessive drinking habit	_____
_____	20. Attempted suicide	_____
_____	21. Motion sickness requiring drugs	_____
_____	22. Admission to hospital within the last 12 months	_____
_____	23. Operations involving eyes, brain, heart, nerves or blood vessels	_____
_____	24. Amputation or physical disability	_____
_____	25. Other illnesses	_____
_____	26. Immunization against tetanus (by toxoid)--list date below	_____
_____	27. Tetanus boosters--list dates below	_____
_____	28. Rejection for life insurance	_____
_____	29. Medical rejection from or for military service	_____
_____	30. Military medical discharge	_____
_____	31. Disability compensation from the Veterans Administration, compensation insurance company, or any government agency.	_____

REMARKS:_____

_____

_____

B. List any medication currently used (including eye drops). _____

C. Have you had an automobile accident, including racing, in the past two (2) years? If yes, explain or describe._____

This is to certify that the above statements are true and accurate. I also give permission to any hospital, institution or physician to furnish any information relative to my condition.

APPLICANT'S SIGNATURE_____DATE_____

WITNESS' SIGNATURE_____DATE_____

(Examining Physician)