

Do you now or have you ever had a problem with any of the following:

Yes	No	Asthma	Yes	No	Kidney / Liver
Yes	No	Diabetes	Yes	No	Rupture / Hernia
Yes	No	Dizziness / Fainting Spells	Yes	No	Severe Motion Sickness
Yes	No	Epilepsy	Yes	No	Back Pain / Spinal Injury
Yes	No	Frequent / Severe Headaches	Yes	No	Shortness of Breath
Yes	No	Hay Fever	Yes	No	Stomach/Intestinal/Ulcers
Yes	No	Heart Trouble	Yes	No	Swollen / Painful Joints
Yes	No	Hypoglycemia	Yes	No	Hypothermia
Yes	No	Night Blindness	Yes	No	Mountain Sickness
Yes	No	Color Blindness	Yes	No	Hemorrhoids
Yes	No	Claustrophobia	Yes	No	Hydrophobia
Yes	No	Acrophobia	Yes	No	Heat Illness

List any illness or injury other than those already noted:

List any injuries to bones or joints:

List any medical problems, illness, injuries, or chronic conditions that you have been treated for by clinics, physicians, or other practitioners within the last five years.

List any medications that you are currently taking:

Person to Notify In Case of an Emergency

Name:

Relationship:

Address:

(Street)

(City)

(State)

(Zip Code)

Telephone Number:

