



Signature

Date

I certify that the above information is complete and true. I understand that inaccurate, false or missing information will invalidate the examination and any medical clearance issued.

Multiple horizontal lines for signature and date.

REMARKS:

- 1. Loss of hand or foot  Yes  No
- 2. Repairment of foot or leg  Yes  No
- 3. Impairment of hand or finger  Yes  No
- 4. Diabetes requiring insulin  Yes  No
- 5. Heart trouble  Yes  No
- 6. Fainting spells or blackouts  Yes  No
- 7. Shortness of breath  Yes  No
- 8. Asthma or wheezing  Yes  No
- 9. Obstructive lung disease  Yes  No
- 10. High blood pressure  Yes  No
- 11. Arthritis  Yes  No
- 12. Muscular problems  Yes  No
- 13. Neurologic disease or head injury  Yes  No
- 14. Epilepsy (seizures)/Tremors  Yes  No
- 15. Mental condition  Yes  No
- 16. Nervous disorder  Yes  No
- 17. Alcoholism  Yes  No
- 18. Ulcer, heartburn, or reflux  Yes  No
- 19. Liver disorder  Yes  No
- 20. Kidney or urinary disorder  Yes  No
- 21. Cancer  Yes  No
- 22. Illegal drug use  Yes  No
- 23. Chronic pain condition  Yes  No
- 24. Impaired Vision  Yes  No
- 25. Color blindness  Yes  No
- 26. Do you use a hearing aid?  Yes  No
- 27. Back pain or injury  Yes  No
- 28. Carpal tunnel syndrome  Yes  No
- 29. Hernia  Yes  No
- 30. Arm, shoulder, or neck pain  Yes  No
- 31. Knee pain or "trick knee"  Yes  No
- 32. Allergies  Yes  No
- 33. Fear of heights or confined spaces  Yes  No
- 34. Do you take any medications? (list below)  Yes  No
- 35. Do you smoke?  Yes  No
- 36. Have you been hospitalized for any \_\_\_\_\_ How long \_\_\_\_\_  Yes  No
- 37. Do you have any other medical or surgical condition?  Yes  No

DO YOU HAVE or HAVE YOU EVER HAD any of the following? IF "YES" GIVE DETAILS IN REMARKS SECTION BELOW.