Candidate Health History

Have you ever had surgery? If “yes”, please list and explain below.: □ Yes □ No □ Not Sure
Enter Surgery Comments ...

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)?
If "yes”, please describe below.: □ Yes □ No □ Not Sure

Do you have or have you ever had:

1. Head/brain Injuries or illnesses *(e.g., concussion)*: □ Yes □ No □ Not Sure
2. Seizures, epilepsy: □ Yes □ No □ Not Sure
3. Eye problems *(except glasses or contacts)*: □ Yes □ No □ Not Sure
4. Ear and/or hearing problems: □ Yes □ No □ Not Sure
5. Heart disease, heart attack, bypass, or other heart problems: □ Yes □ No □ Not Sure
6. pacemaker, stents, implantable devices, or other heart procedures: □ Yes □ No □ Not Sure
7. High blood pressure: □ Yes □ No □ Not Sure
8. High cholesterol: □ Yes □ No □ Not Sure
9. Chronk (long-term) cough, shortness of breath. or other breathing problems: □ Yes □ No □ Not Sure
10. Lung disease *(e.g., asthama)*: □ Yes □ No □ Not Sure
11. Kidney problems. kidney stones, or pain/problems with urination: □ Yes □ No □ Not Sure
12. Stomach. liver, or digestive problems: □ Yes □ No □ Not Sure
13. Diabetes or blood sugar problems: □ Yes □ No □ Not Sure Insulin used: □ Yes □ No □ Not Sure
14. Anxiety, depression, nervousness, other mental health problems: □ Yes □ No □ Not Sure
15. Fainting or passing out: □ Yes □ No □ Not Sure
16. Dizziness. headaches. numbness, tingling, or memory loss: □ Yes □ No □ Not Sure
17. Unexplained weight loss: □ Yes □ No □ Not Sure
18. Stroke, mini-stroke (TIA), paralysis, or weakness: □ Yes □ No □ Not Sure
19. Missing or limited use of arm. hand. finger, leg, foot. toe: □ Yes □ No □ Not Sure
20. Neck or back problems: □ Yes □ No □ Not Sure
21. Bone, muscle, Joint. or nerve problems: □ Yes □ No □ Not Sure
22. Blood clots or bleeding problems: □ Yes □ No □ Not Sure
23. Cancer: □ Yes □ No □ Not Sure
24. Chronic (long-term) infection or other chronic diseases: □ Yes □ No □ Not Sure
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring: □ Yes □ No □ Not Sure
26. Have you ever had a sleep test *(e.g., sleep apnea)?*: □ Yes □ No □ Not Sure
27. Have you ever spent a night in the hospital?: □ Yes □ No □ Not Sure
28. Have you ever had a broken bone?: □ Yes □ No □ Not Sure
29. Have you ever used or do you now use tobacco? : □ Yes □ No □ Not Sure
30. Do you currently drink alcohol?: □ Yes □ No □ Not Sure
31. Have you used an illegal substance within the past two years?: □ Yes □ No □ Not Sure
32. Have you ever failed a drug test or been dependent on an illegal substance?: □ Yes □ No □ Not Sure

Other health condition(s) not described above: □ Yes □ No □ Not Sure
Enter Other Comments ...

Date:

Signature