

Do you have or have you had any of the following? (circle all that apply)

Sinuses/Allergy	Meningitis	Mumps
Measles	Thyroid	Diabetes
Stroke	Heart Attack	High Blood Pressure
Head Injury	Arthritis	Appetite Change
AIDS/HIV	Cancer	Blood Disorder
High Cholesterol	Chicken Pox	Diphtheria
Encephalitis	Fatigue	Genetic Disorders
Headaches	Heart Problems	High Fevers
Scarlet Fever	Stroke	Tonsillitis
Vascular Problems	Typhoid	
Other:		

Do you take medications regularly? YES / NO (please list on separate sheet provided)

Have you ever been exposed to excessively loud noises? YES / NO

Are you currently employed? YES / NO / RETIRED

What is or was your occupation?

PLEASE CHECK ALL MEDICAL SYMPTOMS THAT APPLY:

- Eye Problems (such as blurred vision or pain): YES / NO
- Nose, throat or mouth problems (such as trouble swallowing, nose bleeds, denture issues, pain): YES / NO
- Cardiovascular Symptoms
 (such as hypertension, chest pain, swelling, palpitations, heart surgery): YES / NO
- Respiratory Symptoms (such as shortness of breath, cough, wheezing): YES / NO
- Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea): YES / NO
- Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma): YES / NO
- Neurological Symptoms (such as numbness, headaches, seizures, muscle weakness): YES / NO
- Psychiatric Issues (such as depression, anxiety, compulsions): YES / NO
- Endocrine Symptoms (such as frequent urination, hot flashes): YES / NO
- Hematologic/ Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands, clotting issues): YES / NO
- Allergic/ Immunologic Symptoms (such as hives, asthma, itching, immune deficiency): YES / NO

DOCTORS NOTES		
	Otto Pop 97	
	Confederation of	