

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

(CHECK ALL THAT APPLY)

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| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HYPERTENSION (HIGH BLOOD PRESSURE) |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> INFECTIOUS DISEASE (E.G., TUBERCULOSIS, HEPATITIS) |
| <input type="checkbox"/> BLOOD DISORDERS | <input type="checkbox"/> KIDNEY PROBLEMS |
| <input type="checkbox"/> BROKEN BONES/FRACTURES | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> LOW BACK PAIN |
| <input type="checkbox"/> CIRCULATION/VASCULAR PROBLEMS | <input type="checkbox"/> LOW BLOOD PRESSURE |
| <input type="checkbox"/> COPD (CHRONIC OBSTRUCTIVE PULMONARY DISORDER) | <input type="checkbox"/> MULTIPLE SCLEROSIS |
| <input type="checkbox"/> DEEP VEIN THROMBOSIS / PE | <input type="checkbox"/> MUSCULAR DYSTROPHY |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> OSTEOARTHRITIS |
| <input type="checkbox"/> DEVELOPMENTAL OR GROWTH PROBLEMS | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> PARKINSON DISEASE |
| <input type="checkbox"/> EATING DISORDER | <input type="checkbox"/> PERIPHERAL NEUROPATHY |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> PSYCHIATRIC DISORDERS |
| <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> REPEATED INFECTIONS |
| <input type="checkbox"/> GERD (GASTRO-ESOPHAGEAL REFLUX DISORDER) | <input type="checkbox"/> SEIZURES / EPILEPSY |
| <input type="checkbox"/> HEAD INJURY | <input type="checkbox"/> SPINAL CORD INJURY |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SKIN DISEASES |
| <input type="checkbox"/> HEART ATTACK / MI | <input type="checkbox"/> STOMACH PROBLEMS / ULCERS |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> HEARING IMPAIRMENT | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> HYPERCHOLESTEREMIA (HIGH CHOLESTEROL) | <input type="checkbox"/> VISION IMPAIRMENT |
| | <input type="checkbox"/> OTHER |

IN THE PAST YEAR, HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

(CHECK ALL THAT APPLY)

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| <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> JOINT PAIN, SWELLING OR REDNESS |
| <input type="checkbox"/> BOWEL PROBLEMS | <input type="checkbox"/> LOSS OF APPETITE |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> LOSS OF BALANCE OR FALLING |
| <input type="checkbox"/> CONSTANT PAIN IN BODY | <input type="checkbox"/> LOSS OF PLEASURE IN THINGS
USUALLY ENJOYED |
| <input type="checkbox"/> COORDINATION PROBLEMS | <input type="checkbox"/> NAUSEA / VOMITING |
| <input type="checkbox"/> COUGH | <input type="checkbox"/> NUMBNESS OR CHANGES IN
SENSATION |
| <input type="checkbox"/> DIFFICULTY SLEEPING | <input type="checkbox"/> PAIN AT NIGHT |
| <input type="checkbox"/> DIFFICULTY OR CHANGES IN
SWALLOWING | <input type="checkbox"/> PAIN OR CRAMPING IN LOWER LEG
(CALF) |
| <input type="checkbox"/> DIFFICULTY WALKING | <input type="checkbox"/> PROLONGED FATIGUE |
| <input type="checkbox"/> DIZZINESS OR BLACKOUTS | <input type="checkbox"/> PULSATING PAIN IN BODY |
| <input type="checkbox"/> EXCESSIVE THIRST | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> FEELING DOWNHEARTED OR BLUE | <input type="checkbox"/> STRESS / TENSION |
| <input type="checkbox"/> FEVER / CHILLS / SWEATS | <input type="checkbox"/> UNUSUAL LUMPS OR GROWTHS |
| <input type="checkbox"/> FOOT PAIN / DISCOLORATION | <input type="checkbox"/> UNUSUAL MENSTRUAL
IRREGULARITIES |
| <input type="checkbox"/> FREQUENT OR SEVERE HEADACHES | <input type="checkbox"/> URINARY PROBLEMS |
| <input type="checkbox"/> FREQUENT HEARTBURN OR
INDIGESTION | <input type="checkbox"/> VISION PROBLEMS (I.E., BLURRED
VISION OR LOSS OF SIGHT) |
| <input type="checkbox"/> HEARING IMPAIRMENT | <input type="checkbox"/> WEAKNESS IN ARMS OR LEGS |
| <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> WEIGHT LOSS / GAIN |
| <input type="checkbox"/> HEART PALPITATIONS | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> HOARSENESS OR CHANGES IN
SPEECH | |
| <input type="checkbox"/> INSOMNIA | |