
II Past Illness Or Medical Problems

Do you now have, or have you ever had, any of the following conditions? If so, please check the blank and state when:

- Surgical operations: _____
- Confinement to hospital _____
- Frequent headaches _____
- Fainting spells, dizziness or weakness _____
- Weakness or illness when exposed to high temperatures _____
- Epilepsy or convulsions _____
- Numbness or tingling _____
- Nosebleeds _____
- Difficulty hearing _____
- Heart murmur _____
- Arthritis _____
- Diabetes (type) _____
- Any abnormal bleeding tendencies _____
- Any allergies—food _____
- drugs/medicines _____
- skin _____
- asthma _____
- Loss of, or serious impairment of, a paired organ (eg., kidney, eye, lung) _____
- Osgood-Schlatter's disease of the knee _____
- Hepatitis or jaundice _____
- Acquired immune deficiency syndrome (AIDS) _____
- Infectious mononucleosis (mono) _____
- Do you take medications regularly? List: _____
- Anything not mentioned? _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Parent or Guardian Signature

Date