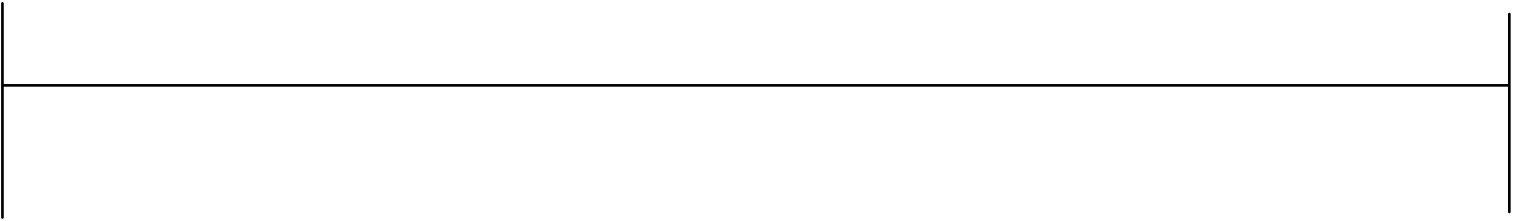


CHECK EACH ITEM "YES" OR "NO", EACH ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT					
YES	NO				
		18. Have you had any significant illness or injury not noted elsewhere <i>(specify condition and dates)?</i>			
		19. Have you ever been a patient in a mental hospital or sanatorium, or been treated by a psychiatrist or psychologist? <i>(Give date, name of doctor and/or hospital, and type of illness)</i>			
		20. Have you been denied life insurance? <i>(Give details)</i>			
21. DO YOU NOW HAVE OR HAVE YOU EVER HAD THE SYMPTOMS LISTED BELOW? <i>(Indicate "Yes" or "No" to Each item)</i>					
YES	NO	(Check each item)	YES	NO	(Check each item)
		Frequent or severe headaches			Kidney trouble, stone or blood urine
		Epilepsy, fits or fainting spells			Sugar or albumin in urine
		Eye trouble or visual defect in either eye			Diabetes
		Skin disease			Rheumatic fever
		Ear, nose or throat trouble			Arthritis, rheumatism or joint pains
		Severe tooth or gum trouble			Painful or "trick" shoulder or knee
		Asthma			Bone, joint or other deformity
		Hay fever or other allergies			Recurrent back pain; wear a back support or brace
		Shortness of breath			Recent gain or loss of weight
		Chronic cough			Malaria, amoebic dysentery or other tropical disease
		Coughing up blood			Stutter or stammer habitually
		Tuberculosis or close association with anyone who had or has tuberculosis			Frequent trouble sleeping
		Pain or pressure in chest			Nervous trouble of any sort
		Palpitation or pounding of heart			Depression or excessive worry
		Swelling of feet or ankles			Attempted suicide
		High blood pressure			Any drug or narcotic habit <i>(specify)</i>
		Frequent indigestion			Excessive bleeding after injury or tooth extraction
		Stomach, liver or intestinal trouble			Any reaction to serum immunization, drug or medicine
		Gall bladder trouble or gall stones			Tumor, growth, cyst, or cancer
		Jaundice or hepatitis			Do you use alcohol?
		Rupture or hernia			Are you a cigarette smoker?
		Piles or other rectal disease			Do you use any medication regularly (specify)
		Blood in or on stool, or black (tarry) stool			
		Frequent or painful urination			
FEMALES ONLY					
Specify any GYN surgery or disease					
Date of last Menses:					
<i>I CERTIFY THAT I HAVE READ THE ABOVE INSTRUCTIONS AND ANSWERED ALL QUESTIONS TRUTHFULLY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE.</i>					
22. TYPED OR PRINTED NAME OF EXAMINEE			DATE		SIGNATURE OF EXAMINEE
NOTE For the Examining Physician: Please review the Medical History and make appropriate comments on all positive historical data. You are required to inform the examinee of any abnormality which you have noted and/or which may require medical attention.					
23. SIGNIFICANT AND/OR INTERVAL HISTORY: (Note: the examining physician MUST COMMENT on all items checked "Yes" in items 16-21).					



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