PERSONAL HEALTH HISTORY
(To be filled out by applicant)

Name _____

Do you have or have you ever had any of the following? Give approximate date.

	Past	Present	N/A		Past	Present	N/A
Epilepsy	___	___	_____	Asthma	___	___	_____
Major accidents	___	___	_____	Stroke	___	___	_____
High blood pressure	___	___	_____	Vision limitation	___	___	_____
Heart Disease	___	___	_____	Severe headaches	___	___	_____
Arthritis	___	___	_____	Chronic fatigue	___	___	_____
Pneumonia	___	___	_____	Thyroid problems	___	___	_____
Cancer	___	___	_____	Emphysema	___	___	_____
Ulcer	___	___	_____	Diabetes	___	___	_____
Circulatory disease	___	___	_____	Orthopedic problems	___	___	_____
Alcohol/Drug abuse	___	___	_____	Mental Health Issues	___	___	_____
Kidney disease	___	___	_____	Smoke cigarettes	___	___	_____
Hepatitis	___	___	_____	Other condition	___	___	_____
Muscular disease	___	___	_____				

List any hospitalizations. Give reason and date:

_____

_____

Are you currently taking any medication? If yes, give type and reason:

_____

_____

_____

_____

Are you managing any chronic conditions? If so, what do you do to remain healthy?

_____

_____

Do you have or have you had any medical problems that may limit the number and kind of children for whom you could care?

_____

_____

Signature _____

Date _____