Have you had or do you have any of the following?

Arthritis or Rheumatism	☐ Yes	☐ No	Details: _____
Osteoporosis	☐ Yes	☐ No	Details: _____
Asthma – carry puffer, last attack	☐ Yes	☐ No	Details: _____
Diabetes – Type 1 or 2	☐ Yes	☐ No	Details: _____
Heart Condition – Nitro, carried	☐ Yes	☐ No	Details: _____
Hypertension (High BP)	☐ Yes	☐ No	Details: _____
Hypotension	☐ Yes	☐ No	Details: _____
Dizziness/Fainting	☐ Yes	☐ No	Details: _____
Epilepsy	☐ Yes	☐ No	Details: _____
Hearing Impairment	☐ Yes	☐ No	Details: _____
Vision Impairment	☐ Yes	☐ No	Details: _____
Anemia	☐ Yes	☐ No	Details: _____
Cancer	☐ Yes	☐ No	Details: _____
Mental Health	☐ Yes	☐ No	Details: _____
Emphysema	☐ Yes	☐ No	Details: _____
Hypoglycemia	☐ Yes	☐ No	Details: _____
Shortness of Breath	☐ Yes	☐ No	Details: _____
Carpal Tunnel Syndrome	☐ Yes	☐ No	Details: _____

Injury to:

( ) Shoulder ( ) Wrist ( ) Back

( ) Hip (replacement) ( ) Knee (replacement) ( ) Other: _____

Participant's Signature: _____

Date: _____