

# List of Health Issues to Report on Application

Name: \_\_\_\_\_

Check all and include a brief comment/explanation where necessary.

<u>CONDITION</u>	<u>COMMENT/EXPLANATION</u>	
Infertility	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Physical Deformity	NO <input type="checkbox"/>	YES <input type="checkbox"/>
AIDS	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Syphilis	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Gonorrhea	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Other Sexually Transmitted Diseases	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Epilepsy	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Schizophrenia	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Bi-Polar, Manic Depression, Psychosis	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Other Mental Illness	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Sickle Cell Anemia	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Vision Problems	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Hearing Problems	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Other issues (i.e. homosexuality)	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Compulsive habits or addictions to gambling, pornography, drugs or alcohol	NO <input type="checkbox"/>	YES <input type="checkbox"/>
Hereditary medical condition or disease	NO <input type="checkbox"/>	YES <input type="checkbox"/>

Please note any medications you are currently taking.

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Other serious illness – Please explain.

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