

## **Individual Membership Medical Questionnaire**

High Blood Pressure Seizures High Cholesterol Lung Disease Heart Attack Stroke Cancer MS Kidney Disease Blood Disorder Mental Illness HIV/AIDS  Other:  Are you currently under the care of a medical provider? Yes No (If yes, provider name and for what condition.)  Provider Name: Condition:  Provider Name: Condition:  Surgical History—Please list previous surgeries with approximate dates:  Medication History (List current medications and dosage. If more space is needed, continue on back):  Medication Name Dosage Times per day  Allergies:  I attest that the above information is complete and accurate and denotes my complete current and past medical history.	Applicant Name:		Date of Birth:		
High Blood Pressure Thyroid Arthritis Bladder Disord Heart Disease Seizures High Cholesterol Lung Disease Heart Attack Stroke Cancer MS Kidney Disease Blood Disorder Mental Illness HIV/AIDS  Other:  Are you currently under the care of a medical provider? Yes No (if yes, provider name and for what condition.)  Provider Name: Condition:  Provider Name: Condition:  Surgical History—Please list previous surgeries with approximate dates:  Medication History (List current medications and dosage. If more space is needed, continue on back):  Medication Name Dosage Times per day  Allergies:  I attest that the above information is complete and accurate and denotes my complete current and past medical history.	CURRENT / PAST MEDICAL HI	ISTORY FOR WHICH YOU	J ARE/HAVE BEEN TREATED— $c$	heck all that apply:	
High Blood Pressure Seizures High Cholesterol Lung Disease Heart Attack Stroke Cancer MS Kidney Disease Blood Disorder Mental Illness HIV/AIDS  Other:  Are you currently under the care of a medical provider? Yes No (If yes, provider name and for what condition.)  Provider Name: Condition:  Provider Name: Condition:  Surgical History—Please list previous surgeries with approximate dates:  Medication History (List current medications and dosage. If more space is needed, continue on back):  Medication Name Dosage Times per day  Allergies:  I attest that the above information is complete and accurate and denotes my complete current and past medical history.	Diabetes	Stomach/Colon Prob	Bone Disorder	Depression	
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Ridney Disease					
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	Allergies:				
Signature: Today's Date:	I attest that the above information i	s complete and accurate and	denotes my complete current and pa	ast medical history.	
	Signature:		Today's Date:		