

Do you have a history of or experience any of the following symptoms or problems

Please circle **YES** or **NO** for each problem

**YES NO** Blurry Vison

**YES NO** Glaucoma

**YES NO** Ringing in your ears

**YES NO** Clenching your teeth

**YES NO** Tightness in your chest or chest pain

**YES NO** Heart disease or irregular heart beats

**YES NO** Need to sleep sitting up in order to get your breath

**YES NO** Difficulty breathing

**YES NO** Emphysema or asthma

**YES NO** Abdominal pain

**YES NO** Stomach ulcer or gastritis

**YES NO** Irregular bowel

**YES NO** Irritable bowel disease

**YES NO** Blood in your stool

**YES NO** Pelvic pain

**YES NO** Frequent urination

**YES NO** Inability to urinate

**YES NO** Seizures

**YES NO** Frequent headache

**YES NO** Episodes of blacking out or passing out

**YES NO** Unexplained fevers

**YES NO** Excessive fatigue

**YES NO** Difficulty falling asleep or staying asleep

**YES NO** Rashes

**YES NO** Rheumatoid arthritis, lupus, sarcoid or scleroderma

**YES NO** Diabetes

**YES NO** Thyroid problems

**YES NO** Depression

**YES NO** Anxiety