1. Has a doctor or health care professional ever told you that you had any of the following? Please check the appropriate boxes.

	Yes	No	Don't Know
a. Anxiety Disorder	☐	☐	☐
b. Asthma	☐	☐	☐
c. Attention Deficit Hyperactivity Disorder (ADD/ADHD)	☐	☐	☐
d. Cancer If Yes, which type: 1. Prostate Cancer ☐ Yes ☐ No 2. Breast Cancer ☐ Yes ☐ No 3. Colon Cancer ☐ Yes ☐ No 4. Blood Cancer (leukemia, lymphoma, other) ☐ Yes ☐ No	☐	☐	☐
e. Chronic Bronchitis	☐	☐	☐
f. Depression	☐	☐	☐
g. Diabetes If Yes: 1. Are you taking medicine for this? ☐ Yes – If Yes, what: ☐ Insulin ☐ Pills ☐ No – If No, what: ☐ Diet controlled ☐ Nothing	☐	☐	☐
h. Emphysema or COPD	☐	☐	☐
i. Epilepsy (Seizure Disorder)	☐	☐	☐
j. Gastroesophageal Reflux Disease (GERD)	☐	☐	☐
	Yes	No	Don't Know
k. High Blood Pressure or hypertension If Yes: 1. Are you taking medicine for this? ☐ Yes ☐ No	☐	☐	☐

l. High Blood Cholesterol If Yes: 1. Are you taking medicine for this? ☐ Yes ☐ No	☐	☐	☐
m. Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease)	☐	☐	☐
n. Insomnia	☐	☐	☐
o. Migraine Headaches	☐	☐	☐
p. Multiple Sclerosis	☐	☐	☐
q. Restless Legs or Periodic Leg Movements	☐	☐	☐
r. Rheumatoid Arthritis, Lupus, or other Collagen Vascular Disease	☐	☐	☐
s. Sinus Problems	☐	☐	☐

2. Have any of the following family members had any of the listed medical conditions (include blood relatives only):

		Yes	No	Don't Know
a. Parents	1. Heart Attack	☐	☐	☐
	2. Stroke	☐	☐	☐
	3. Sleep Apnea	☐	☐	☐
b. Siblings (brothers or sisters) If you don't have any siblings, please mark this box: ☐ N/A	1. Heart Attack	☐	☐	☐
	2. Stroke	☐	☐	☐
	3. Sleep Apnea	☐	☐	☐
c. Children If you don't have any children, please mark this box: ☐ N/A	1. Heart Attack	☐	☐	☐
	2. Stroke	☐	☐	☐
	3. Sleep Apnea	☐	☐	☐