〔Form D〕

Health Declaration Form

（1） Are you currently being treated for any illnesses or injuries?

☐ No

☐ Yes → Name of illness or injury：

Name, dose, and frequency of any medication：

（2） Have you ever been admitted to hospital as a result of stress?

☐ No

☐ Yes → If yes, when? Year: Month:

（3） Do you have any allergies?

☐ No

☐ Yes → What are you allergic to?

What symptoms do you get on exposure?

（4） Do you have any chronic illnesses or injuries that must be pointed out?

☐ No

☐ Yes → Please give details of illnesses or injuries and their treatment details）

（5） Do you smoke?

☐ No

☐ Yes → Amount: (per day)

（6） Do you drink alcohol?

☐ No

☐ Yes → Type and amount: (per week)

（7） (For women only)

Do you take painkillers for pain related to menstruation?

☐No

☐Yes → Name, dose, and frequency of any medication：

I declare that the above information is true and correct:

Signature____________________________________ Date: (Y) (M) (D)