

Return completed forms to:  
Willed Body Program, P.O. Box 245045, Tucson, AZ 85724-5045

## MEDICAL QUESTIONNAIRE

**Date:** \_\_\_\_\_ **Telephone No.** \_\_\_\_\_

**Your Full Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Surgical History:** \_\_\_\_\_

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**Major Health Problems:** \_\_\_\_\_

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**Deformities or Amputations:** \_\_\_\_\_

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