The ZERO-G Experience - Medical History Form

The purpose of this form is to verify that you are in good health or that your personal physician has determined that any existing medical condition(s) will not adversely affect your participation in the *ZERO-G* Experience.

Personal Medical History:

Have you ever had or received medical treatment for any of the following conditions? Circle all that apply.

Frequent or severe headaches or head injury in the last five years	Weakened limbs or joints or broken bones within the past year
Eye trouble (except glasses), ear disease, hearing loss or balance disorders	Behavioral health issues, such as anxiety or panic attacks, fear of heights, fear of flying or fear of closed spaces
Neck, back or other spinal problems	Currently pregnant
Diabetes	Brain or neurological disorders: epilepsy, seizures, stroke, paralysis, multiple sclerosis or others
History of GERD or other blood disorders	Dizziness, blackouts, fainting spells, or loss of consciousness for any reason
High or low blood pressure	Recent severe illness, surgery, or admission to hospital
Heart or vascular trouble, stroke, history of angina or chest pain	Medical rejection, medical discharge from military or other disabilities
Stomach, liver, esophageal or intestinal trouble	Lung disease, breathing problems, asthma or others

Questions:

1. Are you able to walk up a flight of stairs without difficulty? ❒ YES ❒ NO
2. Do you have any trouble clearing sinus blocks? ❒ YES ❒ NO
3. Do you have any allergies? If so, please list all._____
   _____
4. Do you have any conditions that require you to take prescription medications? If so, please list the conditions and medications._____
   _____

Initial One Only:

_____ I have experienced one or more of the above conditions, but I have consulted with my physician and have been advised that my condition(s) will not affect my safe participation in the *ZERO-G Experience.* I have attached my physician's note.
* Physician form templates available upon request.

_____ I have **not** experienced any of these conditions.

The information I have provided about my medical history is true to the best of my knowledge. I agree to accept the responsibility for omissions regarding my failure to disclose any existing or past health condition(s).

_____ _____
Signature *Date*

_____ _____
Printed Name *Flight Date*

4601 North Fairfax Drive, Suite 1200 ● Arlington, VA 22203
Ph: (888) 664-7284 or (703) 524-7176 ● Fax: (702) 947-6373
www.gozerog.com ● info@gozerog.com