

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME - FIRST NAME - MIDDLE NAME		2. SOCIAL SECURITY OR IDENTIFICATION NO.	
3. HOME ADDRESS (No. street or RFD, city or town, State and ZIP Code)		4. POSITION (title, grade, component)	
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)	

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)

I AM IN _____ HEALTH AND TAKING: (LIST MEDICATIONS): _____
 (POOR, FAIR, GOOD, EXCELLENT)

HAVE YOU EVER HAD ANY ADVERSE REACTION TO INSECT BITES OR STINGS? YES OR NO

9. HAVE YOU EVER (Please check each item)				10. DO YOU (Please check each)			
YES	NO	(Check each item)		YES	NO	(Check each item)	
		Lived with anyone who had tuberculosis				Wear glasses or contact lenses	
		Coughed up blood				HAVE VISION IN BOTH EYES	
		Bled excessively after injury or tooth extraction				Wear hearing aid	
		Attempted suicide				Stutter or stammer habitually	
		Been a sleepwalker				Wear a brace or back support	

11. HAVE YOU EVER HAD OR HAVE YOU NOW (*Please check at left of each item* .)

YES	NO	DON'T KNOW	(check each item)	YES	NO	DON'T KNOW	(check each item)	YES	NO	DON'T KNOW	(check each item)
			Scarlet Fever, erysipelas				Cramps in your legs				"Trick" or lock knee
			Rheumatic Fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or gallstones				Paralysis (include infantile)
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye trouble				Adverse reaction to serum, drug				Car, train, sea or air sickness
			Ear, nose, or throat trouble				or medicine				Frequent trouble sleeping
			Hearing loss				Broken bones				Depression or excessive worry
			Chronic or frequent colds				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Severe tooth or gum trouble				Rupture / hernia				Nervous trouble of any sort
			Sinusitis				Piles or rectal disease				Periods of unconsciousness
			Hay Fever				Frequent or painful urination				
			Head Injury				Bed wetting since age 12				
			Skin diseases				Kidney stone or blood in urine				
			Thyroid trouble				Sugar or albumin in urine				
			Tuberculosis				VD - Syphilis, gonorrhea, etc				
			Asthma				Recent gain or loss of weight				
			Shortness of breath				Arthritis, Rheumatism, or Bursitis				
			Pain or pressure in chest				Bone, joint or other deformity				
			Chronic cough				Lameness				
			Palpitation or pounding heart				Loss of finger or toe				
			Heart trouble				Painful or "trick" shoulder or elbow				12. FEMALES ONLY: HAVE YOU EVER
			High or low blood pressure				Recurrent back pain				Been treated for a female disorder
											Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?	14. ARE YOU (Check one)
	<input type="checkbox"/> Right handed <input type="checkbox"/> Left handed

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT		
		15. Have you been refused employment or been unable to hold a job or stay in school because of: A: Sensitivity to chemicals, dust, sunlight, etc.		
		B: Inability to perform certain motions.		
		C: Inability to assume certain positions.		
		D: Other medical reasons (If yes, give reasons.)		
		16. Have you ever been treated for mental condition? (If yes, specify when, where, and give details.)		
		17. Have you ever been denied life insurance? (If yes, state reason and give details.)		
		18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which it occurred.)		
		19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why and name of doctor and complete address of hospital.)		
		20. Have you ever had any illness or injury oth than those already noted? (If yes, specify when, where, and give details.)		
		21. Have you consulted or been treated by clini physicians, healers, or other practitioners within the past 5 years for other than mino illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		
		22. Have you ever been rejected for military service because of physical, mental, or oth reasons? (If yes, give date and reason for rejection.)		
		23. Have you ever been discharged from milita service because of physical, mental, or oth reasons? (If yes, give date, reason, and typ of discharge: whether honorable, other tha honorable, for unfitness or unsuitability.)		
		24. Have you ever received, is there pending, o have you applied for pension or compensation for existing disability? (If ye specify what kind, granted by whom, and amount, when, why.)		
I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.				
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.				
TYPE OR PRINT NAME OF EXAMINEE		EXAMINEE SIGNATURE		
NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."				
25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 9 thru 24. Physician may develop by interview any additional medical history he or she deems important, and record any significant findings here.)				
TYPE OR PRINT NAME OF PHYSICIAN OR EXAMINER		DATE		SIGNATURE
				NUMBER OF ATTACHED SHEETS