REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0413 OMB approval expires Mar 31, 2010

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN). **PRINCIPAL PURPOSE(S):** To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confine-ment or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than

nonorable discharge that would affect your future.					
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFI)	K)	2. 8	SOCIAL SECURITY NUMBER 3. TODAY'S DATE (YYYYMMD)	D)	
4.a. HOME ADDRESS (Street, Apartment No., City, State	e, and ZIP Code)	5.	EXAMINING LOCATION AND ADDRESS (Include ZIP Code)		
b. HOME TELEPHONE (Include Area Code)		_			
S. HOME TEEL HOME (module rived code)					
X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Co	mpone	nt)
6.a. SERVICE b. COMPONENT	c. PURPOSE OF EX	AMI	NATION		
Army Coast Guard Active Duty	Enlistment		Medical Board Other (Specify)		
Navy Reserve	Commission		Retirement b. USUAL OCCUPATION		
Marine Corps National Guard	Retention		U.S. Service Academy		
Air Force	Separation		ROTC Scholarship Program		
8. CURRENT MEDICATIONS (Prescription and Over-the	e-counter)	9.	ALLERGIES (Including insect bites/stings, foods, medicine or other substan	ce)	
Mark each item "YES" or "NO". Every item mark	rked "YES" must b	e ful	lly explained in Item 29 on Page 2.		
HAVE YOU EVER HAD OR DO YOU NOW HAVE	: YES NO	1 [12. (Continued)	YES	NO
10.a. Tuberculosis	0 0		f. Foot trouble (e.g., pain, corns, bunions, etc.)	0	0
b. Lived with someone who had tuberculosis	0 0		g. Impaired use of arms, legs, hands, or feet	0	0
c. Coughed up blood	0 0		h. Swollen or painful joint(s)	0	0
d. Asthma or any breathing problems related to exercise, wea pollens, etc.	ther,		i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	0	0
e. Shortness of breath	0 0		 Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint 	0	0
f. Bronchitis	0 0		 Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. 	0	0
g. Wheezing or problems with wheezing	0 0		I. Bone, joint, or other deformity	0	0
h. Been prescribed or used an inhaler	0 0		m. Plate(s), screw(s), rod(s) or pin(s) in any bone	0	0
i. A chronic cough or cough at night	0 0		n. Broken bone(s) (cracked or fractured)	0	0
j. Sinusitis	0 0		13.a. Frequent indigestion or heartburn	0	0
k. Hay fever	0 0		b. Stomach, liver, intestinal trouble, or ulcer	0	0
I. Chronic or frequent colds	0 0		c. Gall bladder trouble or gallstones	0	0
11.a. Severe tooth or gum trouble	0 0		d. Jaundice or hepatitis (liver disease)	0	0
b. Thyroid trouble or goiter	0 0		e. Rupture/hernia	0	0
c. Eye disorder or trouble	0 0		f. Rectal disease, hemorrhoids or blood from the rectum	0	0
d. Ear, nose, or throat trouble	0 0		g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	0	0
e. Loss of vision in either eye	0 0		h. Frequent or painful urination	0	0
f. Worn contact lenses or glasses	0 0		i. High or low blood sugar	0	0
g. A hearing loss or wear a hearing aid	0 0		j. Kidney stone or blood in urine	0	0
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	0 0		k. Sugar or protein in urine	0	0
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation	ion, etc.)		 Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.) 	0	0
b. Arthritis, rheumatism, or bursitis	0 0		14.a. Adverse reaction to serum, food, insect stings or medicine	0	0
c. Recurrent back pain or any back problem	0 0		b. Recent unexplained gain or loss of weight	0	0
d. Numbness or tingling	0 0		c. Currently in good health (If no, explain in Item 29 on Page 2.)	0	0
e Loss of finger or toe	0 0		d Tumor growth cyst or cancer	\bigcirc	

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below. HAVE YOU EVER HAD OR DO YOU NOW HAVE: 15. Discreases of initing pools 15. Carl review headscurke 26. A head injusy, memory lose or annesia 26. Peralysis 27. Earl review headscurke 28. Securious, consultations, polipsey or fine 29. Estreams, consultations, polipsey or fine 29. A period of unconsciousness or concussion 29. A period of unconsciousness or concussion 29. Period of unconsciousness 29. Period o	LAS	NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER			
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15.a. Dizziness or fainting spells b. Frequent or severe headache c. A head injury, memory loss or amnesia d. Paralysis e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meinightis, encephalitis, or other neurological problems d. Paralysis d. Paralysis e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meinightis, encephalitis, or other neurological problems f. Paralysis d. Paralysis d. Paralysis e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meinightis, encephalitis, or other neurological problems f. Heave you ever been treated in an Emergency Room? fly yes, for what? 21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and compilete address of hospital). 22. Have you ever had or have you been advised to have any operations or surgery? (If yes, specify when, where, and give details.) 23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) 24. Have you consulted or been treated by clinic, and details. 25. Have you ever been discharged from military service for any reason? (If yes, give date and reason for rejection.) 26. Have you ever been discharged from military service for any reason? (If yes, give date, neason, and type of discharge. 27. Have you ever been discharged from military service for any reason? (If yes, give date, neason, and type of discharge. 28. Have you ever been discharged from military service for any reason? (If yes, give date, neason, and type of discharge.) 29. Explanation of Yeys' what kind, granted by whom, and what amount, when, why.) 29. Explanation of poblem. 29. Explanation of some of doctor is and service in any careful and the service in any careful and the service in any reason? (If yes, give date, neason, and type					y explained in item 25 below.	VEC	NO
b. Frequent or severe headache c. A head injury, memory loss or amnesia d. Paralysis e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meningitis, encephalitis, or other neurological problems b. Prolonged bleeding (as after an injury or tooth extraction, etc.) c. Pain or pressure in the chest d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur f. High or low blood pressure 17.a. Nervous trouble of any sort (anxiety or panic attacks) b. Habitual stammering or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent trouble sleeping f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs 18. FEMALES ONLY. Have you ever had or do you now have: a. Treatment for a gynecological (female) disorder c. Any abnormal PAP smears d. First day of last menstrual period (YYYYMMDD) 29. ExPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem. memor of doctor)s and/or hospital(s), treatment given and current medical					40 Have you have refused employment or bear unable to hold a job	IES	NO
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e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meningitis, encephalitis, or other neurological problems 16.a. Rheumatic fever b. Prolonged bleeding (as after an injury or tooth extraction, etc.) c. Pain or pressure in the chest d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur f. High or low blood pressure 17.a. Nervous trouble of any sort (anxiety or panic attacks) b. Habitual stammering or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent trouble sleeping e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs b. A change of menstrual pattern c. Any abnormal PAP smears d. First day of last menstrual period (YYYYMMDD) s. Date of last PAP smear (YYYYMMDD) 29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical			_				
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e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs 18. FEMALES ONLY. Have you ever had or do you now have: a. Treatment for a gynecological (female) disorder b. A change of menstrual pattern c. Any abnormal PAP smears d. First day of last menstrual period (YYYYMMDD) e. Date of last PAP smear (YYYYMMDD) 29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(clinic, and details.) 25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) 26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) 27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) 28. Have you ever been denied life insurance?	d.	Frequent trouble sleeping			other than minor illnesses? (If yes, give complete address	0	0
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NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAS	ST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBE	R	
30.	EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTIN questions 10 - 29. Physician/practitioner may develop by interview significant findings here.)	IENT DATA (Physician/practitio w any additional medical history	ner shall comment on all por deemed important, and red	ositive answers in cord any
a.	COMMENTS			
b.	TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial)	c. SIGNATURE		d. DATE SIGNED
				(YYYYMMDD)