

REPORT OF MEDICAL HISTORY

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

Form Approved
OMB No. 0704-0413
Expires Aug 31, 2003

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 Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. 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 ADDRESS. 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.

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 confinement 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 honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)	PHYSICAL EXAMS DEWITT ARMY HOSPITAL FT. BELVOIR, VA 22060 703-806-3397	

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program	b. USUAL OCCUPATION

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	○	○	f. Foot trouble (e.g., pain, corns, bunions, etc.)	○	○
b. Lived with someone who had tuberculosis	○	○	g. Impaired use of arms, legs, hands, or feet	○	○
c. Coughed up blood	○	○	h. Swollen or painful joint(s)	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	○	○
e. Shortness of breath	○	○	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
f. Bronchitis	○	○	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
g. Wheezing or problems with wheezing	○	○	l. Bone, joint, or other deformity	○	○
h. Been prescribed or used an inhaler	○	○	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
i. A chronic cough or cough at night	○	○	n. Broken bone(s) (cracked or fractured)	○	○
j. Sinusitis	○	○	13.a. Frequent indigestion or heartburn	○	○
k. Hay fever	○	○	b. Stomach, liver, intestinal trouble, or ulcer	○	○
l. Chronic or frequent colds	○	○	c. Gall bladder trouble or gallstones	○	○
11.a. Severe tooth or gum trouble	○	○	d. Jaundice or hepatitis (liver disease)	○	○
b. Thyroid trouble or goiter	○	○	e. Rupture/hernia	○	○
c. Eye disorder or trouble	○	○	f. Rectal disease, hemorrhoids or blood from the rectum	○	○
d. Ear, nose, or throat trouble	○	○	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	○	○
e. Loss of vision in either eye	○	○	h. Frequent or painful urination	○	○
f. Worn contact lenses or glasses	○	○	i. High or low blood sugar	○	○
g. A hearing loss or wear a hearing aid	○	○	j. Kidney stone or blood in urine	○	○
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	○	○	k. Sugar or protein in urine	○	○
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	○	○	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	○	○
b. Arthritis, rheumatism, or bursitis	○	○	14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
c. Recurrent back pain or any back problem	○	○	b. Recent unexplained gain or loss of weight	○	○
d. Numbness or tingling	○	○	c. Currently in good health (If no, explain in Item 29 on Page 2.)	○	○
e. Loss of finger or toe	○	○	d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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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:	YES	NO		YES	NO	
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:			
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>		c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons <i>(If yes, give reasons.)</i>	<input type="radio"/>	<input type="radio"/>
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? <i>(If yes, for what?)</i>		
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>				
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		21. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i>		
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	22. Have you ever had, or have you been advised to have any operations or surgery? <i>(If yes, describe and give age at which occurred.)</i>			
b. Prolonged bleeding <i>(as after an injury or tooth extraction, etc.)</i>	<input type="radio"/>	<input type="radio"/>				
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>				
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>				
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>				
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>				
17.a. Nervous trouble of any sort <i>(anxiety or panic attacks)</i>	<input type="radio"/>	<input type="radio"/>	23. Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i>			
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>				
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>				
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>				
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>				
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>				
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>				
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>				
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>				
18. FEMALES ONLY. Have you ever had or do you now have:			24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i>			
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>				
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>				
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>				
d. First day of last menstrual period <i>(YYYYMMDD)</i>	<input type="radio"/>	<input type="radio"/>				
e. Date of last PAP smear <i>(YYYYMMDD)</i>	<input type="radio"/>	<input type="radio"/>	25. Have you ever been rejected for military service for any reason? <i>(If yes, give date and reason for rejection.)</i>			
26. Have you ever been discharged from military service for any reason? <i>(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)</i>			<input type="radio"/>	<input type="radio"/>		
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i>			<input type="radio"/>	<input type="radio"/>		
28. Have you ever been denied life insurance?			<input type="radio"/>	<input type="radio"/>		

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 status.)*

PATIENT EXPLANATION	PROVIDER NOTES

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

