NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM
		7/9/25

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT *(Last, first, middle)*	2. IDENTIFICATION NUMBER	3. GRADE
Doe, John	1000	C

4a. HOME STREET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)*	5. EXAMINING FACILITY
100 Church St.	Building D

4b. CITY	4c. STATE	4d. ZIP CODE
Townville	CA	99999

6. PURPOSE OF EXAMINATION

Recent weight gain — 10 lbs in a week

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Use additional pages if necessary)*

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
No observed issues with health. Active several days/week		
c. ALLERGIES *(Include insect bites/stings and common foods)*		

d. HEIGHT	e. WEIGHT
5'10	190

8. PATIENT'S OCCUPATION	9. ARE YOU *(Check one)*
Accountant	☑ RIGHT HANDED ☐ LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis		✓		Shortness of breath		✓		Bone, joint or other deformity		✓	
				Pain or pressure in chest		✓		Loss of finger or toe		✓	
Tuberculosis or positive TB test		✓		Chronic cough		✓		Painful or "trick" shoulder or elbow		✓	
Blood in sputum or when coughing		✓		Palpitation or pounding heart		✓					
				Heart trouble		✓		Recurrent back pain or any back injury		✓	
Excessive bleeding after injury or dental work		✓		High or low blood pressure			✓				
				Cramps in your legs		✓		"Trick" or locked knee		✓	
Suicide attempt or plans		✓		Frequent indigestion		✓		Foot trouble		✓	
Sleepwalking	✓			Stomach, liver or intestinal trouble		✓		Nerve Injury		✓	
Wear corrective lenses	✓			Gall bladder trouble or gallstones		✓		Paralysis *(including infantile)*		✓	
Eye surgery to correct vision		✓						Epilepsy or seizure		✓	
Lack vision in either eye		✓		Jaundice or hepatitis		✓		Car, train, sea or air sickness		✓	
Wear a hearing aid		✓		Broken bones	✓			Frequent trouble sleeping		✓	
Stutter or stammer		✓		Adverse reaction to medication			✓	Depression or excessive worry		✓	
Wear a brace or back support		✓		Skin diseases		✓		Loss of memory or amnesia		✓	
Scarlet fever		✓		Tumor, growth, cyst, cancer		✓		Nervous trouble of any sort		✓	
Rheumatic fever		✓		Hernia		✓		Periods of unconsciousness		✓	
Swollen or painful joints		✓		Hemorrhoids or rectal disease		✓		Parent/sibling with diabetes, cancer, stroke or heart disease		✓	
Frequent or severe headaches		✓		Frequent or painful urination		✓					
Dizziness or fainting spells		✓		Bed wetting since age 12		✓		X-ray or other radiation therapy		✓	
Eye trouble		✓		Kidney stone or blood in urine		✓		Chemotherapy		✓	
Hearing loss		✓		Sugar or albumin in urine		✓		Asbestos or toxic chemical exposure			✓
Recurrent ear infections		✓		Sexually transmitted diseases		✓					
Chronic or frequent colds		✓		Recent gain or loss of weight	✓			Plate, pin or rod in any bone		✓	
Severe tooth or gum trouble		✓		Eating disorder (anorexia bulimia, etc.)		✓		Easy fatigability			✓
Sinusitis		✓						Been told to cut down or criticized for alcohol use		✓	
Hay fever or allergic rhinitis		✓		Arthritis, Rheumatism, or Bursitis		✓					
Head injury		✓						Used illegal substances	✓		
Asthma		✓		Thyroid trouble or goiter			✓	Used tobacco	✓		

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
Treated for a female disorder	☐	☐	☐			
Change in menstrual pattern	☐	☐	☐			

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. 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.)*	☐	✓
13. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*	☐	✓
14. Have you ever been denied life insurance? *(If yes, state reason and give details.)*	☐	✓
15. Have you had, or have you been advised to have, any operation. *(If yes, describe and give age at which occurred.)*	☐	✓
16. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	☐	✓
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	☐	✓
18. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)*	☐	✓
19. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	☐	✓
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	☐	✓
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. *(If yes, provide details.)*	☐	✓
22. Have you ever been diagnosed with a learning disability? *(If yes, give type, where, and how diagnosed.)*	☐	✓

23. LIST ALL IMMUNIZATIONS RECEIVED

Flu COVID-19 HPV Chicken-Pox Polio

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. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE
John Doe	John Doe	7/9/25

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 Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE