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 wou	ila allect your future.							
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)				2. 5	SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYM	MDD)	
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)				5.	EXAMINING LOCATION AND ADDRESS	(Include ZIP Code)		
b. HOME TELEPHONE (Include	e Area Code)							
X ALL APPLICABLE BOXES	S:					7.a. POSITION (Title, Grade,	Compone	ent)
6.a. SERVICE	b. COMPONENT c	. PURPOSE O	F EX	IIMA	NATION			
Army Coast Guard	Active Duty	Enlistment			Medical Board Other (Specify)			
Navy	Reserve	Commission	n		Retirement	b. USUAL OCCUPATION		
Marine Corps	National Guard	Retention			U.S. Service Academy			
Air Force		Separation	l		ROTC Scholarship Program			
8. CURRENT MEDICATIONS (F	Prescription and Over-the-c	counter)		9.	ALLERGIES (Including insect bites/stings	, foods, medicine or other subs	stance)	
Mayle and item "VEC" or "A	IO" Even item moule	ad "VES"	ot b	- f	lly explained in Item 29 on Page 2.			
HAVE YOU EVER HAD OR I		YES		e iui I [12. (Continued)		VES	NO
10.a. Tuberculosis	DO TOU NOW HAVE.		_		f. Foot trouble (e.g., pain, corns, bun	ions etc.)	()	0
b. Lived with someone who ha	ad tuboroulogia	0	0		g. Impaired use of arms, legs, hands,	•	0	0
	au tuberculosis	0	0		h. Swollen or painful joint(s)	or reer		0
 c. Coughed up blood d. Asthma or any breathing proble pollens, etc. 	ms related to exercise, weather	er.	0			noin or ligament injury, etc.)	0	0
		_	0		 i. Knee trouble (e.g., locking, giving out, j. Any knee or foot surgery including arthro to any bone or joint 		0	0
e. Shortness of breath f. Bronchitis		0	0		to any bone or joint k. Any need to use corrective devices such	as prosthetic devices, knee	0	_
	1	0	0		k. Any need to use corrective devices such brace(s), back support(s), lifts or orthotics	s, etc.	0	0
g. Wheezing or problems with	-	0	0		Bone, joint, or other deformity Blots(a), sersey(a), red(a) or pin(a); Blots(b), sersey(a), red(c), or pin(a); Blots(c), sersey(a), red(c), red(c), red(c), red(c), red(c); Blots(c), sersey(a), red(c),	n any hana	0	0
h. Been prescribed or used an inhaler		0	0		m. Plate(s), screw(s), rod(s) or pin(s)	•	0	0
i. A chronic cough or cough a	at night	0	0		n. Broken bone(s) (cracked or fractur	<i>9u)</i>	$\frac{\circ}{\circ}$	0
j. Sinusitis		0	0		13. a. Frequent indigestion or heartburn		0	0
k. Hay fever		0	0		b. Stomach, liver, intestinal trouble, o	r uicer	0	0
Chronic or frequent colds	•	0	0		c. Gall bladder trouble or gallstones	1	0	0
11.a. Severe tooth or gum trouble	e e	0	0		d. Jaundice or hepatitis (liver disease)	0	0
b. Thyroid trouble or goiter		0	0		e. Rupture/hernia	ad from the reature		0
c. Eye disorder or trouble		0	0		f. Rectal disease, hemorrhoids or blo		0	0
d. Ear, nose, or throat trouble		0	0		g. Skin diseases (e.g. acne, eczema,	psoriasis, etc.)		0
e. Loss of vision in either eye		0	0		h. Frequent or painful urination		0	0
f. Worn contact lenses or gla		0	0		i. High or low blood sugar		0	0
g. A hearing loss or wear a he	=	0	0		j. Kidney stone or blood in urine		0	0
 h. Surgery to correct vision (RK, PRK, LASIK, etc.) 12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) 		0	0		k. Sugar or protein in urine	norrhea chlamydia genital	0	0
		_	0		Sexually transmitted disease (syphilis, go warts, herpes, etc.)		$\overline{\bigcirc}$	0
b. Arthritis, rheumatism, or bu		0	0		14.a. Adverse reaction to serum, food, in	-	0	0
c. Recurrent back pain or any	back problem	0	0		b. Recent unexplained gain or loss of	<u>.</u>	0	0
d. Numbness or tingling		0	0		c. Currently in good health (If no, exp	iain in item 29 on Page 2.)	0	0
A LOSS OF TINGER OF TOA		/ /	/ \		a lumor arowth ever or cancer			- ()

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 15.a. Discrimes or faining spells. C. A hard playr, memory loss or amenals. C. A hard playr, memory loss or amenals. S. Seatures, convulsions, apilepsy or fits C. Car, train, service in the critical or an injury or footing the convulsions. S. A period of unconsociuranes or concussion C. Panalysis in the critical or or an injury or footing the convulsions. D. Proloped bleading fits after an injury or footin obtanchor, etc.) C. Panal or pleasure in the critical or market or amenator and conversal hours for the conversal hours f	LAS	Γ NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER			
HAVE YOU EVER HAD OR DO YOU NOW HAVE: YES NO							
HAVE YOU EVER HAD OR DO YOU NOW HAVE: YES NO	Mar	ceach item "VES" or "NO" Every item marked "VES" r	nust he	full	v explained in Item 29 below		
15.a. Dizziness or fainting spells b. Frequent or severe headache c. A head injuy, 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 f. Paralysis c. Pain or pressure in the chest d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or numur f. High or low blood pressure f. High or low blood pressure f. Heart 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 seeping 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 f. Happ you ever been discharged from military service for any reason? (If yes, give date and reason for rejection.) 18. FRAMLES ONLY. Have you ever head 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, name of doctor(s) and/or hospital(s), treatment given and current medical					y explained in item 25 below.	VES	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. Meningiis, encephalitis, or other neurological problems h. Habitual stammering or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent 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 steeping 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 mens					40 Have you have refused employment or been unable to hold a job	IES	NO
c. A head injury, memory loss or amnesia d. Parahysis e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meningilis, 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 b. Habitual stammering or stuttering d. Frequent trouble steeping 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) 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(s), treatment given and current medical		0 1	_				
d. Paralysis e. Seizures, convulsions, epilepsy or fits O. 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) 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		·			a. Sensitivity to chemicals, dust, sunlight, etc.	\circ	\cap
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) 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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h. Meningitis, encephalitis, or other neurological problems 16.a. Rheumatic fever			_		d. Other medical reasons (If yes, give reasons.)	Ö	
h. Meningitis, encephalitis, or other neurological problems 16.a. Rheumatic fever			0		20 Have you ever been treated in an Emergency Room?		
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 18. FEMALES ONLY. Have you ever had or do you now have: a. Treatment for a gynecological (female) disorder b. A change of menstrual partern 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 and complete address or address of hospital.) 21. Nave you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which operations or surgery? (If yes, specify when, where, why, and name of doctor and complete address or hospital.) 22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, specify when, where, why, and name of doctor and complete address or surgery? (If yes, specify when, where, why, and name of doctor and complete address or not prepatitions or surgery? (If yes, specify when, where, why, and name of doctor and complete address or poperations or surgery? (If yes, specify when, where, and give details.) 24. Have you ever had any illness or injury other than those already noted? (If yes, give onsulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other practitioners within the past 5 years for other practicion.) 24. Have you ever been rejected for military service for any reason? (If yes, give date, reason, and type of discharge; whether t	h.	Meningitis, encephalitis, or other neurological problems	0			0	\circ
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 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(s), treatment given and current medical address of hospital.) 22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) 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 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.) 25. Have you ever been rejected for military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unifitness or unsuitability.) 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, other	16. a.	Rheumatic fever	0	0	21 Have you ever been a natient in any type of hospital? (If yes		
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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 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(s), treatment given and current medical	f.	High or low blood pressure	0	0	occurred.)		
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 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) 24. 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.) 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, spectry what kind, granted by whom, and what amount, when, why.) 28. Have you ever been denied life insurance? 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	17. a.	Nervous trouble of any sort (anxiety or panic attacks)	0	0		\circ)
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 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 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(s), treatment given and current medical	b.	Habitual stammering or stuttering	0	0	already noted? (If yes, specify when, where, and give details.)	0	
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preason? (If yes, give date and reason for rejection.) 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(s), treatment given and current medical					25. Have you ever been rejected for military convice for any		
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) 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 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 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.)	•		_			\circ	0
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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) 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?			_	^	whether honorable, other than honorable, for unfitness or	O	O
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e. Date of last PAP smear (YYYYMMDD) 28. Have you ever been denied life insurance? 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		•	O	O	or injury? (If yes, specify what kind, granted by whom,	\circ	\circ
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		, , , ,					$\overline{}$
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	S	tatus.)					

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)