NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM

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
4a. HOME STREET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)*			5. EXAMINING FACILITY	
4b. CITY	4c. STATE	4d. ZIP CODE		
6. PURPOSE OF EXAMINATION				

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.
c. ALLERGIES *(Include insect bites/stings and common foods)*		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION	9. ARE YOU *(Check one)* ☐ 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

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

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