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

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)
PUBLIC, JOHN Q.	123-45-6789	20090818

4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)
123 MAIN STREET OCEANSIDE, CA 92057	9TH BN, 5TH LAR Camp Pendleton, CA 92055
b. HOME TELEPHONE (Include Area Code) 760-555-1234	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION			
[ ] Army [ ] Coast Guard	[X] Active Duty	[ ] Enlistment	[ ] Medical Board	[X] Other (Specify)	
[X] Navy	[ ] Reserve	[ ] Commission	[ ] Retirement	NSW/SO DUTY	
[ ] Marine Corps	[ ] National Guard	[ ] Retention	[ ] U.S. Service Academy		
[ ] Air Force		[ ] Separation	[ ] ROTC Scholarship Program		

7.a. POSITION (Title, Grade, Component): SGT/E-5

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
NONE	PENICILLIN - RASH

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
10.a. Tuberculosis	○	●
b. Lived with someone who had tuberculosis	○	●
c. Coughed up blood	○	●
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	●
e. Shortness of breath	○	●
f. Bronchitis	○	●
g. Wheezing or problems with wheezing	○	●
h. Been prescribed or used an inhaler	○	●
i. A chronic cough or cough at night	○	●
j. Sinusitis	○	●
k. Hay fever	○	●
l. Chronic or frequent colds	○	●
11.a. Severe tooth or gum trouble	○	●
b. Thyroid trouble or goiter	○	●
c. Eye disorder or trouble	○	●
d. Ear, nose, or throat trouble	○	●
e. Loss of vision in either eye	○	●
f. Worn contact lenses or glasses	●	○
g. A hearing loss or wear a hearing aid	○	●
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	●	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	●
b. Arthritis, rheumatism, or bursitis	○	●
c. Recurrent back pain or any back problem	○	●
d. Numbness or tingling	○	●
e. Loss of finger or toe	○	●

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	●
g. Impaired use of arms, legs, hands, or feet	●	○
h. Swollen or painful joint(s)	○	●
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	●
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	●
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	●
l. Bone, joint, or other deformity	○	●
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	●
n. Broken bone(s) *(cracked or fractured)*	●	○
13.a. Frequent indigestion or heartburn	○	●
b. Stomach, liver, intestinal trouble, or ulcer	○	●
c. Gall bladder trouble or gallstones	○	●
d. Jaundice or hepatitis *(liver disease)*	○	●
e. Rupture/hernia	●	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	●
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	●
h. Frequent or painful urination	○	●
i. High or low blood sugar	○	●
j. Kidney stone or blood in urine	○	●
k. Sugar or protein in urine	○	●
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	●	○
14.a. Adverse reaction to serum, food, insect stings or medicine	●	○
b. Recent unexplained gain or loss of weight	○	●
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	●	○
d. Tumor, growth, cyst, or cancer	○	●

Reset

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
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. 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	○	●
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)*		

	YES	NO
19. 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 stand, sit, kneel, lie down, etc.	○	●
d. Other medical reasons *(If yes, give reasons.)*	○	●
20. Have you ever been treated in an Emergency Room? *(If 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 complete 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 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?	○	●

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.)*

11.f. I used to wear contact lenses.
11.h. I had PRK in 2008
12.g. I broke my wrist playing football in high school.
12.n. See 12.g.
13.e. My appendix burst when I was 12.
13.l. I was treated for genital warts two years ago.
14.a. I was told that I broke out in hives as a child when I received penicillin.
20. I went to the emergency room for my wrist and my appendix
21. I was hospitalized for my appendix.
22. I had my appendix removed.

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

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30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

11.f, 11h. Patient previously wore corrective lenses until undergoing PRK at NNMC Bethesda in NOV08. - NCD

12.g, 12.n. The patient sustained closed left distal radius and ulnar fracture in 2004. Treated with closed reduction and short arm cast. Well-healed, no sequelae. - NCD

13.e. The patient reports a history of appendicitis complicated by ruptured appendix. he underwent open appendectomy at Washington Adventist Hospital, Washington, DC in 1999. No sequelae. - NCD

13.l. - The patient was treated for HPV infection with cryotherapy at BMC Quantico in 2007. Completely resolved. - NCD

14.a. - The patient has a documented allergy to penicillin. - NCD

14.c. The patient states he is currently in good health. - NCD

20. The patient was evaluated at the Washington Adventist Hospital in 1999 for appendicitis listed in 13.e. He was also evaluated at a community urgent care facility in 2004 for the closed fractures described in 12.g, 12.n. - NCD

21,22. See 13.e, 20. - NCD

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*
SMITH, ROBERT A. LT, MC (GMO), USN	R. Smith	20090806