# DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
# REPORT OF MEDICAL HISTORY

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

*OMB No. 0704-0396*
*OMB approval expires Nov 30, 2009*



**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO DODMERB/DR, 8034 EDGERTON DRIVE, SUITE 132, USAF ACADEMY CO 80840-2200.**

## PRIVACY ACT STATEMENT

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397.

**PRINCIPAL PURPOSE:** To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

**ROUTINE USES:** This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applications to their Academies.

**DISCLOSURE:** Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

| 1. NAME *(Last, First, Middle Initial)* | 2. SOCIAL SECURITY NUMBER | 3. TELEPHONE NO. *(Include area code)* |
|---|---|---|
| | | |

| 4. PURPOSE OF EXAMINATION | 5. EXAMINATION FACILITY OR EXAMINER AND ADDRESS *(Include ZIP Code)* | 6. DATE OF EXAMINATION *(YYYYMMDD)* |
|---|---|---|
| ARMY ROTC | | |

Mark each item "Yes" or "No". **EVERY QUESTION MUST BE ANSWERED, OR PROCESSING DELAYS WILL OCCUR.** Every "Yes" must be explained in Block 83, REMARKS, on the back of the form. Mark and explain each item to the best of your ability. Be perfectly honest! Your medical records may be requested to clarify your medical history.

| 7. HAVE YOU EVER OR DO YOU NOW USE ANY OF THE FOLLOWING: | YES | NO |
|---|---|---|
| Amphetamines | | |
| Barbiturates | | |
| Cocaine | | |
| Narcotic Drugs | | |
| Marijuana | | |
| Alcohol *(Amount, frequency, treatment, if any)* | | |
| Chemical Inhalants | | |
| Hallucinogens | | |

| DO YOU | YES | NO |
|---|---|---|
| 8. Wear glasses | | |
| 9. Wear contact lenses or corneal eye retainers *(If Yes, complete 9a.)* | | |
| 10. HAVE YOU EVER HAD YOUR VISION IMPROVED BY METHODS OTHER THAN STATED IN QUESTIONS 8 OR 9? | | |

**9a. If you wear contact lenses, how many days have they been removed prior to this examination?**

| Less than 3 | | 3 - 20 | | 21 or over |
|---|---|---|---|---|
| Type lens: | | Hard | | Soft |

| HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO |
|---|---|---|
| 11. Eye trouble *(exclude glasses, contact lenses)* | | |
| 12. Have fluctuating vision or double vision | | |
| 13. Have any allergies | | |
| 14. Take any medications regularly | | |
| 15. Stutter or stammer | | |
| 16. Frequent, severe, or migraine headaches | | |
| 17. Fainting or dizzy spells | | |
| 18. Periods of unconsciousness | | |
| 19. Head injury or skull fracture | | |
| 20. Epilepsy, seizures or convulsions | | |
| 21. Loss of memory *(amnesia)* | | |
| 22. Depression, anxiety, excessive worry, or nervousness | | |
| 23. Any mental condition or illness | | |
| 24. Frequent trouble sleeping | | |
| 25. Hearing loss | | |
| 26. Ear, nose, or throat trouble | | |
| 27. Sinusitis or sinus trouble | | |
| 28. Hay fever or allergic rhinitis | | |
| 29. Tooth/gum trouble, or current orthodontics | | |
| 30. Thyroid trouble | | |
| 31. Chronic cough or lung disease | | |
| 32. Asthma or wheezing | | |
| 33. Unusual shortness of breath | | |
| 34. Pain or pressure in chest | | |
| 35. Palpitation or pounding heart | | |
| 36. Heart trouble or heart murmur | | |
| 37. High blood pressure | | |
| 38. Coughed up or vomited blood | | |
| 39. Stomach, liver, or intestinal trouble | | |

| | YES | NO |
|---|---|---|
| 40. Gallbladder trouble or gallstones | | |
| 41. Hepatitis *(yellow jaundice)* | | |
| 42. Hemorrhoids or rectal disease | | |
| 43. Black or bloody stools | | |
| 44. Frequent or painful urination | | |
| 45. Bed wetting after age 12 | | |
| 46. Blood, protein, or sugar in urine | | |
| 47. History of diabetes | | |
| 48. Kidney stone | | |
| 49. Hernia or rupture | | |
| 50. Any bone or joint problem, injuries, surgery or medical treatment | | |
| 51. Steel pins, plates, or staples in any bones | | |
| 52. Wear a bone or joint brace or support | | |
| 53. Back pain or trouble | | |
| 54. Paralysis or weakness | | |
| 55. Foot trouble/use orthotics | | |
| 56. Rheumatic fever | | |
| 57. Tuberculosis or positive TB test | | |
| 58. Sexually transmitted disease *(syphilis, gonorrhea, herpes)* | | |
| 59. Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin | | |
| 60. Adverse reaction to vaccines, drugs, medicines, foods, insect bites or stings | | |
| 61. Eating disorder | | |
| 62. Recent gain or loss of weight | | |
| 63. Excessive bleeding or easy bruising | | |
| 64. Tumor, growth, cyst, or cancer | | |
| 65. Considered or attempted suicide | | |

| | YES | NO |
|---|---|---|
| 66. Sleepwalking episodes after age 12 | | |
| 67. Easily fatigued | | |
| 68. Motion sickness *(car, train, sea, or air)* | | |
| 69. X-ray or other radiation therapy | | |
| 70. Sensitivity to chemicals, dust, sunlight, etc. | | |
| 71. Learning disabilities or speech problems | | |
| **HAVE YOU EVER** | **YES** | **NO** |
| 72. Been refused employment or been unable to hold a job or stay in school because of: | | |
| a. Inability to perform certain movements? | | |
| b. Inability to assume certain positions? | | |
| c. Other medical reasons? | | |
| 73. Been rejected for or discharged from military service because of physical, mental or other reasons? | | |
| 74. Been denied or rated up for life insurance? | | |
| 75. Received or applied for pension or compensation for existing disability? | | |
| 76. Had or been advised to have, any surgical operations? | | |
| 77. Consulted, or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses? | | |
| 78. Had any injury or illness other than those already noted? | | |
| **FEMALES ONLY** *(Complete Items 79 - 82)* | **YES** | **NO** |
| 79. Been treated for a female disorder, painful periods, or cramps | | |
| 80. Had a change in menstrual pattern | | |
| 81. Are you now pregnant? | | |
| 82. Date of last menstrual period *(YYYYMMDD)* | | |

**83. REMARKS. Applicant use only.** Every "yes" response in items 7 through 81 must be explained in the space provided. Give specific dates and details including names of physicians and hospitals or clinics and the current status of the condition. If additional space is required, continue on a separate sheet and attach to this form.

**84. CERTIFICATION.** 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 physicians, 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.

| TYPED OR PRINTED NAME OF EXAMINEE/APPLICANT | SIGNATURE OF EXAMINEE/APPLICANT | DATE SIGNED *(YYYYMMDD)* |
|---|---|---|
| | | |

**85. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA.** Examiner shall comment on all "Yes" and blank answers, indicating the item number before each comment. Develop by interview any additional medical history deemed important, and record significant findings here. If additional space is required, continue on a separate sheet and attach to this form.

| 86. EXAMINER | | | 87. NUMBER OF ATTACHED SHEETS |
|---|---|---|---|
| TYPED OR PRINTED NAME OF EXAMINER | SIGNATURE OF EXAMINER | DATE SIGNED *(YYYYMMDD)* | |
| | | | |



Reset