## 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

The public reporting burden for this collection of information is estimated to average 15 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, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (0704-0396). 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 accurrently valid OMB control number.

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. N	IAIVIE	(Last, First, Middle Irillia	'')							2. SOCIAL SECURITY NUMBER	`	3. 1	ELEPHOI	NE NO. (IIIC	iuue ai	rea code)	
4. P	URPC	OSE OF EXAMINATION		5. E	XAMINA	TION I	FACIL	ITY C	R EX	AMINER AND ADDRESS (Include	ZIP C	code)		-	TE OF	<b>EXAMINATION</b> DD)	ī
expl	ained		on the							SWERED, OR PROCESSING I ach item to the best of your ability.							
		YOU EVER OR DO OW USE ANY OF	YES	NO				YES	NO	DO YOU	9a. I	vou w	ear contac	ct lenses, hov	v manv	days have they	
YES		THE FOLLOWING:			Marijuana	a				8. Wear glasses	[	been r	emoved pr	ior to this exa	minati	on?	
		Amphetamines			Alcohol (					9. Wear contact lenses or		Less	than 3	3 - 20		21 or over	
		Barbiturates			frequency if any)	, treati	nent,			corneal eye retainers (If Yes, complete 9a.)		Туре	lens:	Hard		Soft	
		Cocaine			Chemical	Inhala	ants			10. HAVE YOU EVER HAD YOUR VIS	ION IM	PROV	ED BY MET	THODS OTHE	R THAI	N STATED IN	
		Narcotic Drugs			Hallucino	gens				QUESTIONS 8 OR 9?							
YES	NO	HAVE YOU EVER HAD O	R DO Y	OU NO	W HAVE:	YES	NO		<u> </u>		YES	NO					
		11. Eye trouble (exclude g	glasses,	contac	t lenses)			40. G	allbla	dder trouble or gallstones			66. Sleep	walking epis	odes af	ter age 12	_
		12. Have fluctuating vision or double vision					41. H	1. Hepatitis (yellow jaundice)				67. Easily	/ fatigued	tigued			
		13. Have any allergies						42. H	lemorr	hoids or rectal disease			68. Motio	n sickness (d	ar, train	, sea, or air)	
		14. Take any medications	regula	ırly				43. B	lack o	or bloody stools			69. X-ray	or other radia	ation th	erapy	
		15. Stutter or stammer						44. F	reque	nt or painful urination			70. Sensi	tivity to chen	icals, c	dust, sunlight, etc	 :.
		16. Frequent, severe, or r	nigrain	e head	aches			45. B	ed we	tting after age 12			71. Learn	ing disabilitie	s or sp	eech problems	
		17. Fainting or dizzy spel	ls					46. B	lood,	protein, or sugar in urine	YES	NO	HAVE Y	OU EVER			
		18. Periods of unconscio	usness	;				47. H	listory	of diabetes			72. Been	refused emp	ovmen	t or been unable t	to
		19. Head injury or skull fr	acture					48. K	idney	stone						ol because of:	
		20. Epilepsy, seizures or	convul	sions				49. H	lernia	or rupture			a. Ina	bility to perfe	rm cer	tain movements?	·
		21. Loss of memory (amr	nesia)					50. A	ny bo	ne or joint problem, injuries, surgery			b. Ina	bility to assu	me cer	tain positions?	_
		22. Depression, anxiety,	excessi	ive wo	ry, or	1		0	r medi	ical treatment			c. Otl	her medical r	easons	?	_
		nervousness						51. S	teel pi	ins, plates, or staples in any bones						arged from milita	
		23. Any mental condition	or illne	ess				52. V	Vear a	bone or joint brace or support	1		servio reaso		physic	cal, mental or other	er
		24. Frequent trouble slee	ping					53. B	ack pa	ain or trouble			74. Been	denied or rat	ed up f	or life insurance?	,
		25. Hearing loss						54. P	aralys	is or weakness			75. Recei	ved or applie	d for ne	ension or	_
		26. Ear, nose, or throat tr	ouble					55. F	oot tro	puble/use orthotics	1			ensation for			
		27. Sinusitis or sinus trouble						56. R	heum	atic fever		70	76. Had or been advised to have, any surgical				_
		28. Hay fever or allergic r	hinitis					57. T	uberc	ulosis or positive TB test	1			tions?	, , , , , ,	are, any eargrea	
		29. Tooth/gum trouble, or		nt ortho	odontics			58. S	exuall	y transmitted disease (syphilis,				ulted, or beer			_
		30. Thyroid trouble				1		g	onorrh	ea, herpes)						ilers, or other in minor illnesses	;?
		31. Chronic cough or lun	g disea	se				59. S	kin co	onditions such as acne, psoriasis,			78. Had a	ny injury or i	Iness o	other than those	_
		32. Asthma or wheezing				1				r foot rashes, eczema, or dry skin				ly noted?			
		33. Unusual shortness of	breath					60. A	dvers	e reaction to vaccines, drugs,	YES	NO	FEMALE	ES ONLY (C	omplete	e Items 79 - 82)	
		34. Pain or pressure in ch	nest			ĺ				es, foods, insect bites or stings			79. Been treated for a fem		female		
		35. Palpitation or poundi	ng hear	t				61. Eating d		disorder				periods, or cramps			
36. Heart trouble or heart murmur							62. Recent gain or loss of weight 80. Had a change in menstrual				al pattern						
		37. High blood pressure								ive bleeding or easy bruising			81. Are yo	ou now pregr	ant?		
		38. Coughed up or vomite	ed bloo	d				64. T	umor,	growth, cyst, or cancer			82. Date 0	of last menst	ual per	riod (YYYYMMDD)	)

39. Stomach, liver, or intestinal trouble

65. Considered or attempted suicide

83.		onse in items 7 through 81 must be explained in the spoor clinics and the current status of the condition. If add	
84.	. CERTIFICATION. I certify that I have reviewed the f knowledge. I authorize any of the physicians, hospit medical record for purposes of processing my applic	als, or clinics mentioned above to furnish the Governm	and complete to the best of my ent a complete transcript of my
	knowledge. I authorize any of the physicians, hospit	als, or clinics mentioned above to furnish the Governm ation for this employment or service.	nent a complete transcript of my
TY	knowledge. I authorize any of the physicians, hospit medical record for purposes of processing my applic PED OR PRINTED NAME OF EXAMINEE/APPLICA	als, or clinics mentioned above to furnish the Governmation for this employment or service.  NT SIGNATURE OF EXAMINEE/APF	PLICANT  DATE SIGNED (YYYYMMDD)
TY	knowledge. I authorize any of the physicians, hospit medical record for purposes of processing my applic PED OR PRINTED NAME OF EXAMINEE/APPLICA  EXAMINER'S SUMMARY AND ELABORATION OF	als, or clinics mentioned above to furnish the Government of this employment or service.  NT  SIGNATURE OF EXAMINEE/APF  ALL PERTINENT DATA. Examiner shall comment or develop by interview any additional medical history deep	PLICANT  DATE SIGNED (YYYYMMDD)  n all "Yes" and blank answers,
TY	knowledge. I authorize any of the physicians, hospit medical record for purposes of processing my applic PED OR PRINTED NAME OF EXAMINEE/APPLICA  EXAMINER'S SUMMARY AND ELABORATION OF indicating the item number before each comment.	als, or clinics mentioned above to furnish the Government of this employment or service.  NT  SIGNATURE OF EXAMINEE/APF  ALL PERTINENT DATA. Examiner shall comment or develop by interview any additional medical history deep	PLICANT  DATE SIGNED (YYYYMMDD)  n all "Yes" and blank answers,
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