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.)

Form Approved
OMB No. 0704-0396
Expires Aug 31, 2003

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. 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)*

SECTION I

Mark each item "Yes" or "No". Every question must be answered. Every "Yes" must be explained in the REMARKS section. 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. Severe tooth or gum trouble		
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		
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)*		

SECTION II

83. REMARKS. 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. Continue on a separate sheet and attach to this form if additional space is needed.

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	SIGNATURE	DATE SIGNED *(YYYYMMDD)*

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

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 needed, continue on a separate sheet and attach to this form.)*

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