REPORT OF MEDICAL HISTORY

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

OMB No. 0704-0413
OMB approval expires Aug 31, 2014

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).
PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.
ROUTINE USE(S): The Blanket Routine Uses found at http://privacy.defense.gov/blanket_uses.shtml apply to this collection.
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. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

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)*
4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*	**5. EXAMINING LOCATION AND ADDRESS** *(Include ZIP Code)*	
b. HOME TELEPHONE *(Include Area Code)*		

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	7.a. POSITION *(Title, Grade, Component)*
☐ Army ☐ Coast Guard	☐ Regular	☐ Enlistment ☐ Medical Board ☐ Other *(Specify)*	
☐ Navy	☐ Reserve	☐ Commission ☐ Retirement	b. USUAL OCCUPATION
☐ Marine Corps	☐ National Guard	☐ Retention ☐ U.S. Service Academy	
☐ Air Force		☐ Separation ☐ ROTC Scholarship Program	

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*	9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

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	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

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.)*

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

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

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

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The following requirement applies to all students joining the NROTC College Program, as well as to NROTC Scholarship students that have not yet been physically qualified by DODMERB, or for whom BUMED has not yet recommended approval of a waiver of NROTC physical standards.

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UNLESS OTHERWISE EXPRESSLY STATED below, physician certifies that the student is medically qualified to participate in RIGOROUS PHYSICAL TRAINING WITHOUT RESTRICTION as a member of the Naval ROTC Unit, University of Minnesota. The signature of the examining physician below is an ABSOLUTE REQUIREMENT PRIOR TO PARTICIPATION IN ANY NROTC-SPONSORED PHYSICAL TRAINING OR ACTIVITY.

* Physician CONCURS that Student's PHYSICAL ACTIVITY SHOULD NOT BE RESTSRICTED. Physician (please initial);_____

* Physician RECOMMENDS THESE RESTRICTIONS to Student's physical activity (print restrictions clearly, then initial):

_____

_____

_____Physician (please initial);_____

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*