

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

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OMB approval expires  
Sep 30, 2006

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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 and Communications Directorate (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 a currently 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.

<b>1. NAME</b> (Last, First, Middle Initial)		<b>2. SOCIAL SECURITY NUMBER</b>	<b>3. TELEPHONE NO.</b> (Include area code)
<b>4. PURPOSE OF EXAMINATION</b>	<b>5. EXAMINATION FACILITY OR EXAMINER AND ADDRESS</b> (Include ZIP Code)		<b>6. DATE OF EXAMINATION</b> (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			YES	NO	DO YOU	9a. If you wear contact lenses, how many days have they been removed prior to this examination?		
YES	NO			Marijuana				8. Wear glasses			
				Alcohol (Amount, frequency, treatment, if any)				9. Wear contact lenses or corneal eye retainers (If Yes, complete 9a.)			
				Chemical Inhalants					Less than 3	3 - 20	21 or over
				Hallucinogens					Type lens:	Hard	Soft
									10. HAVE YOU EVER HAD YOUR VISION IMPROVED BY METHODS OTHER THAN STATED IN QUESTIONS 8 OR 9?		
YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:				YES	NO				
		11. Eye trouble (exclude glasses, contact lenses)						40. Gallbladder trouble or gallstones			
		12. Have fluctuating vision or double vision						41. Hepatitis (yellow jaundice)			
		13. Have any allergies						42. Hemorrhoids or rectal disease			
		14. Take any medications regularly						43. Black or bloody stools			
		15. Stutter or stammer						44. Frequent or painful urination			
		16. Frequent, severe, or migraine headaches						45. Bed wetting after age 12			
		17. Fainting or dizzy spells						46. Blood, protein, or sugar in urine			
		18. Periods of unconsciousness						47. History of diabetes			
		19. Head injury or skull fracture						48. Kidney stone			
		20. Epilepsy, seizures or convulsions						49. Hernia or rupture			
		21. Loss of memory (amnesia)						50. Any bone or joint problem, injuries, surgery or medical treatment			
		22. Depression, anxiety, excessive worry, or nervousness						51. Steel pins, plates, or staples in any bones			
		23. Any mental condition or illness						52. Wear a bone or joint brace or support			
		24. Frequent trouble sleeping						53. Back pain or trouble			
		25. Hearing loss						54. Paralysis or weakness			
		26. Ear, nose, or throat trouble						55. Foot trouble/use orthotics			
		27. Sinusitis or sinus trouble						56. Rheumatic fever			
		28. Hay fever or allergic rhinitis						57. Tuberculosis or positive TB test			
		29. Tooth/gum trouble, or current orthodontics						58. Sexually transmitted disease (syphilis, gonorrhea, herpes)			
		30. Thyroid trouble						59. Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin			
		31. Chronic cough or lung disease						60. Adverse reaction to vaccines, drugs, medicines, foods, insect bites or stings			
		32. Asthma or wheezing						61. Eating disorder			
		33. Unusual shortness of breath						62. Recent gain or loss of weight			
		34. Pain or pressure in chest						63. Excessive bleeding or easy bruising			
		35. Palpitation or pounding heart						64. Tumor, growth, cyst, or cancer			
		36. Heart trouble or heart murmur						65. Considered or attempted suicide			
		37. High blood pressure									
		38. Coughed up or vomited blood									
		39. Stomach, liver, or intestinal trouble									
									YES	NO	FEMALES ONLY (Complete Items 79 - 82)
											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**

TYPED OR PRINTED NAME

SIGNATURE

DATE SIGNED  
(YYYYMMDD)**87. NUMBER OF  
ATTACHED  
SHEETS**