DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
STATEMENT OF HISTORY REGARDING ALLERGIES

OMB No. 0704-0396
OMB approval expires
Sep 30, 2006

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 OF APPLICANT *(Last, First, Middle Initial)*	**2. SSN OF APPLICANT**

INSTRUCTIONS

Please describe any symptoms or problems you have experienced in the following areas. If additional space is needed, use the reverse side of this form.

3. ALLERGIC RHINITIS (HAYFEVER) OR ANY OTHER ALLERGIES, FREQUENCY/DURATION OF SYMPTOMS

TREATMENT AND/OR MEDICATION. ARE YOU TAKING DESENSITIZATION INJECTIONS?

LIST ANY COMPLICATIONS *(Example: sinusitis, ear blocks, etc.)*

TREATMENT OR SURGERY FOR THE COMPLICATIONS CONSISTED OF:

4. ASTHMA, REACTIVE AIRWAY DISEASE, OR EXERCISE INDUCED BRONCHOSPASM

AGE OF ONSET	**TREATMENT AND/OR MEDICATION**

WERE THERE ANY EMERGENCY ROOM VISITS, OR HOSPITALIZATIONS ASSOCIATED WITH YOUR AIRWAY PROBLEM, TO INCLUDE WHEEZING OR SHORTNESS OF BREATH?

DATE OF LAST ATTACK	**FREQUENCY OF MEDICATION USED** *(Example: daily, weekly, monthly, or just spring and fall seasons)*	**DATE OF LAST TREATMENT OR MEDICATION**

5. DESCRIBE ANY PAST OR PRESENT SKIN PROBLEMS SUCH AS ECZEMA, ATOPIC ECZEMA (ATOPIC DERMATITIS), HIVES OR URTICARIA.

6. DESCRIBE CONTACT ALLERGIES *(Latex, wool, chemicals, etc.)* **AND SYMPTOMS.**

TREATMENT AND/OR MEDICATION

FREQUENCY OF TREATMENT OR MEDICATION USED *(Example: daily, weekly, monthly, or just spring and fall seasons)*	**DATE OF LAST TREATMENT OR MEDICATION**

7. DESCRIBE ANY ALLERGIC REACTIONS TO FOODS, - SYMPTOMS AND SPECIFIC FOOD.

8. SIGNATURE OF APPLICANT	**9. DATE SIGNED**

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