Department of Health and Human Services
Commissioned Corps of the U.S. Public Health Service

REPORT OF MEDICAL HISTORY

(Please read Privacy Act Statement before completing this form.)

OMB No. xxxx-xxxx
OMB approval expires xx/xx/xx

IMPORTANT INSTRUCTIONS: It is intended that this form be completed online. In the event an applicant to the Commissioned Corps of the U.S. Public Health Service cannot complete this form online, the applicant must complete the form in paper format. 'Yes' answers will require the completion of the following questionnaire forms:

Item 13 – PHS-7053, Allergies
Item 16 – PHS-7056, Headache
Item 19 – PHS-7054, Head Injury
Items 50, 51, and 52 – PHS-7055, Injury
Item 53 – PHS-7061, Owestry Low Back
Item 79 – PHS-7057 – GYN

In addition, every 'Yes' response in Items 7 through 81 must be explained in Item 83 of this form.

Return completed form to:

OFFICE OF COMMISSIONED CORPS OPERATIONS
ATTN: MEDICAL EVALUATIONS OFFICER
1101 WOOTTON PARKWAY, SUITE 100, PLAZA LEVEL
ROCKVILLE, MD 20852

***Mark envelope* "TO BE OPENED BY MEDICAL PERSONNEL ONLY"**

AUTHORITY: 42 U.S.C. 202 et seq. and Executive Order 9397.

RECORDS SYSTEM: 09-40-0002, "PHS Commissioned Corps Medical Records," HHS/PSC/HRS.

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical fi le as part of the application process to the Commissioned Corps of the U.S. Public Health Service.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper an applicant's candidacy. Use of the Social Security Number is used

1. NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. TELEPHONE NUMBER *(Include area code)*

4. PURPOSE OF EXAMINATION	5. EXAMINATION FACILITY OR EXAMINER AND ADDRESS *(Include ZIP Code)*	6. DATE OF EXAMINATION *(MM/DD/YYYY)*
	PROOF	

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
		Marijuana			Alcohol *(Amount, frequency, treatment, if any)*			8. Wear glasses
		Amphetamines						9. Wear contact lenses or corneal eye retainers *(If Yes, complete 9a.)*
		Barbiturates						
		Cocaine			Chemical inhalants			10. HAVE YO EVER HAD YOUR VISION IMPROVED BY METHODS OTHER THAN STATED IN QUESTIONS 8 OR 9?
		Narcotic Drugs			Hallucinogens			

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 OF LENS: ☐ Hard ☐ Soft

YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO	
		11. Eye trouble *(exclude glasses, contact lenses)*			40. Gallbladder trouble or gallstones			66. Sleepwalking episodes after age 12
		12. Have fl uctuating vision or double vision			41. Hepatitis *(yellow jaundice)*			67. Easily fatigued
		13. Have any allergies			42. Hemorrhoids or rectal disease			68. Motion sickness *(car, train, sea, or air)*
		14. Take any medications regularly			43. Black or bloody stools			69. X-ray or other radiation therapy
		15. Stutter or stammer			44. Frequent or painful urination			70. Sensitivity to chemicals, dust, sunlight, etc.
		16. Frequent, severe, or migraine headaches			45. Bed wetting after age 12			71. Learning disabilities or speech problems
		17. Fainting or dizzy spells			46. Blood, protein, or sugar in urine	YES	NO	HAVE YOU EVER
		18. Periods of unconsciousness			47. History of diabetes			72. Been refused employment or been unable to hold a job or stay in school because of:
		19. Head injury or skull fracture			48. Kidney stone			
		20 Epilepsy, seizures or convulsions			49. Hernia or rupture			a. Inability to perform certain movements?
		21. Loss of Memory			50. Any bone or joint problem, injuries, surgery or medical treatment			b. Inability to assume certain positions?
		22. Depression, anxiety, excessive worry, or nervousness						c. Other medical reasons?
					51. Steel pins, plates, or staples in any bones			73. Been rejected for or discharged from military service because of physical, mental or other reasons?
		23. Any mental condition or illness			52. Wear a bone or joint brace or support			
		24. Frequent trouble sleeping			53. Back pain or trouble			74. Been denied or rated up for life insurance?
		25. Hearing loss			54. Paralysis or weakness			75. Received or applied for pension or compensation for existing disability?
		26. Ear, nose, or throat trouble			55. Foot trouble / use orthotics			
		27. Sinusitis or sinus trouble			56. Rheumatic fever			76. Had or been advised to have, any surgical operations?
		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)*			77. Consulted, or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?
		30. Thyroid trouble						
		31. Chronic cough or lung disease			59. Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin			78. Had any injury or illness other than those already noted?
		32. Asthma or wheezing						
		33. Unusual shortness of breath			60. Adverse reaction to vaccines, drugs, medicines, foods, insect bites or stings	YES	NO	FEMALES *(Complete Items 79 - 82)*
		34. Pain or pressure in chest						79. Been treated for a female disorder, painful periods, or cramps
		35. Palpitation or pounding heart			61. Eating disorder			
		36. Heart trouble or heart murmur			62. Recent gain or loss of weight			80. Had a change in menstrual pattern
		37. High blood pressure\			63. Excessive bleeding or easy bruising			81. Are you now pregnant?
		38. Coughed up or vomited blood			64. Tumor, growth, cyst, or cancer			82. Date of last menstrual period *(MM/DD/YYYY)* :
		39. Stomach, liver, or intestinal trouble			65. Considered or attempted suicide			

PSC Graphics (301) 443-1090 EF

SECTION II

83. REMARKS. Every "Yes" response in Items 7 through 81 must be explained in the space provided. Give specifi c dates and details including names of physicians and hospitals or clinics and the current status of the condition. If additional space is needed (for versions of this form without expandable fi elds) use the "Continued Page" generating feature if available; otherwise, continue on a separate sheet and attach to this form.

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 or processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE *(MM/DD/YYYY)*
	PROOF	

NOTE: Mail to Offi ce of Commissioned Corps Operations, Attn: Medical Evaluations Offi cer, 1101 Wootton Parkway, Suite 100, Plaza Level, Rockville, MD 20852, and 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 signifi cant fi ndings here. If additional space is needed continue on a separate sheet and attach to this form.)*

ITEMS 85 - 87 MUST NOT BE FILLABLE.
PHYSICIAN / EXAMINER TO FILL THESE ITEMS BY HAND.
(This designer note will be removed on fi nal form.)

86. PHYSICIAN OR EXAMINER

TYPED OR PRINTED NAME	SIGNATURE	DATE *(MM/DD/YYYY)*	**87. NUMBER OF ATTACHED SHEETS**