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

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 HHS / OS Reports Clearance Offi cer, 200 Independence Avenue, SW, Room 537-H, Washington, DC 20012 (PRA 0990-XXXX). 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.

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	
		Amphetamines			Marijuana
		Barbiturates			Alcohol *(Amount, frequency, treatment, if any)*
		Cocaine			Chemical inhalants
		Narcotic Drugs			Hallucinogens

YES	NO	DO YOU
		8. Wear glasses
		9. Wear contact lenses or corneal eye retainers *(If Yes, complete 9a.)*
		10. HAVE YO 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 OF LENS: ☐ Hard ☐ Soft

YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:
		11. Eye trouble *(exclude glasses, contact lenses)*
		12. Have fl uctuating 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
		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. Tooth / gum trouble, or current orthodontics
		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
		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

YES	NO	HAVE YOU EVER
		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?

YES	NO	FEMALES *(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 *(MM/DD/YYYY)* :

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