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

Department of Health and Human Services
Commissioned Corps of the U.S. Public Health Service
Offi ce of Commissioned Corps Operations
ATTN: Medical Evaluations Offi cer
Suite 100, Plaza Level
1101 Wootton Parkway
Rockville, MD 20852

ALLERGIES QUESTIONNAIRE

NAME	SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please complete the following questions regarding history of allergies. *Note:* It is intended that this form be completed online as a link to a 'Yes' answer on Item 13 of form PHS-7060, Report of Medical History. 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 and mail it to the Offi ce of Commissioned Corps Operations at the above address and mark envelope "To be Opened by Medical Personnel Only." If more space is needed (for versions of this form without expandable fi elds), please use the applicable area on page 2.

PRIVACY ACT STATEMENT

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 for positive identifi cation of records.

1. Please list your allergies (e.g., allergic rhinitis, hay fever, other allergies, etc.):

2. Please list the frequency and duration of treatment and/or medication used for allergies:

3. Do you experience any complications from your allergies?

☐ Yes ☐ No If yes, please explain (e.g., sinusitis, ear blocks, etc., and treatment for complications):

4. Have you ever had asthma, reactive airway disease, exercise induced bronchospasm, wheezing or shortness of breath?

☐ Yes ☐ No If yes, please answer 4a, 4b, 4c, 4d, 4e, and 4f below:

4a. Age of onset: _____

4b. Treatment and/or medication(s):

4c. Have you ever been treated for a breathing problem? ☐ Yes ☐ No
If yes, please explain (emergency room visits, hospitalizations, etc.):

4d. Date of last attack: _____

4e. Date of last medication or treatment: _____

4f. Frequency of medication used (e.g., daily, weekly, seasonal, prior to athletic/recreational activities, or as needed):

(Continued)

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ALLERGIES QUESTIONNAIRE ***(Continued)***

5. Have you ever had any past or present skin problems? (e.g., eczema, atopic dermatitis, hives, or urticaria, etc.):
   ☐ Yes ☐ No If yes, please explain (condition, treatment and/or medication, and date of last treatment):

6. Please describe any contact allergies, (e.g., latex, wool, chemicals, etc.) symptoms, treatment and/or medication(s) and date(s):

7. Have you ever had any allergic reactions to foods?
   ☐ Yes ☐ No If yes, please explain (symptoms and specifi c food(s)):

CONTINUED ANSWERS TO PRECEDING QUESTIONS *(If needed when form version does not have expandable fi elds. Please specify question(s))*

CERTIFICATION: By signing below, I hereby certify that all the preceding information is true and accurate to the best of my knowledge.

APPLICANT SIGNATURE	DATE