

Department of Health and Human Services  
 Commissioned Corps of the U.S. Public Health Service  
 Office of Commissioned Corps Operations  
 ATTN: Medical Evaluations Officer  
 Suite 100, Plaza Level  
 1101 Wootton Parkway  
 Rockville, MD 20852  
**HEAD INJURY QUESTIONNAIRE**

The public reporting burden for this collection of information is estimated to average 6 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 Officer, 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.

NAME	SOCIAL SECURITY NUMBER
------	------------------------

**INSTRUCTIONS:** Please complete the following questions regarding history of head injury(ies). *Note:* It is intended that this form be completed online as a link to a 'Yes' answer on Item 19 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 Office 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 fields), 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 file 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 identification of records.

1. How did your head injury(ies) occur?

2. How old were you when it/they happened?

PROOF

3. Did you experience loss of consciousness?  
 Yes     No    If yes, how long:

4. Did you experience amnesia?  
 Yes     No    If yes, how long:

5. Were you treated at a hospital or by a medical provider?  
 Yes     No    If yes, what type(s) of treatment and/or tests was/were accomplished?

6. Did you have any symptoms after the injury (e.g., headaches, vomiting, disorientation, double vision, dizziness, etc.)?  
 Yes     No    If yes, please explain:

(Continued)

**HEAD INJURY QUESTIONNAIRE (Continued)**

7. How long did your symptoms last after your injury, if applicable?

8. Were any additional procedures accomplished (e.g., electroencephalogram, brain scan, burr holes, pneumoencephalogram, etc.)?

Yes     No    If yes, please explain:

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

**PROOF**

**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