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

HEADACHE QUESTIONNAIRE

NAME	SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please complete the following questions regarding history of headaches. *Note:* It is intended that this form be completed online as a link to a 'Yes' answer on Item 16 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. How often have your headaches occurred during the last 3 years (e.g., daily, weekly, quarterly, every six months, etc.)?

2. When headaches occur, what are their frequency (e.g., once a day, twice, three times, other, etc.)?

3. How long do the headaches usually last (e.g., 1 hour, 6 hours, etc.)?

4. Have you ever taken any medications for your headaches?

☐ Yes ☐ No

If yes, please explain in detail (e.g., what medication(s), usual dose, effectiveness of medication(s) etc.):

5. How do headaches interfere with your daily activities?

6. Have you seen a physician or other medical provider for your headaches?

☐ Yes ☐ No If yes, what were the fi ndings?

(Continued)

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HEADACHE QUESTIONNAIRE ***(Continued)***

7. List any other pertinent information regarding your headaches

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