

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
REPORT OF MEDICAL HISTORY**

OMB No. 0704-0396  
OMB approval expires  
Nov 30, 2009

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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 Department of Defense, Executive Services Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (0704-0396). 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.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO DODMERB/DR, 8034 EDGERTON DRIVE, SUITE 132, USAF ACADEMY CO 80840-2200.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397.

**PRINCIPAL PURPOSE:** To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

**ROUTINE USES:** This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applications to their Academies.

**DISCLOSURE:** Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

<b>1. NAME</b> (Last, First, Middle Initial)	<b>2. SOCIAL SECURITY NUMBER</b>	<b>3. TELEPHONE NO.</b> (Include area code)
<b>4. PURPOSE OF EXAMINATION</b>	<b>5. EXAMINATION FACILITY OR EXAMINER AND ADDRESS</b> (Include ZIP Code)	<b>6. DATE OF EXAMINATION</b> (YYYYMMDD)

Mark each item "Yes" or "No". **EVERY QUESTION MUST BE ANSWERED, OR PROCESSING DELAYS WILL OCCUR.** Every "Yes" must be explained in Block 83, REMARKS, on the back of the form. 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	9a. If you wear contact lenses, how many days have they been removed prior to this examination?		
YES	NO					8. Wear glasses			
						9. Wear contact lenses or corneal eye retainers (If Yes, complete 9a.)	Less than 3	3 - 20	21 or over
						10. HAVE YOU EVER HAD YOUR VISION IMPROVED BY METHODS OTHER THAN STATED IN QUESTIONS 8 OR 9?	Type lens:	Hard	Soft
YES	NO			YES	NO		YES	NO	
						11. Eye trouble (exclude glasses, contact lenses)			66. Sleepwalking episodes after age 12
						12. Have fluctuating vision or double vision			67. Easily fatigued
						13. Have any allergies			68. Motion sickness (car, train, sea, or air)
						14. Take any medications regularly			69. X-ray or other radiation therapy
						15. Stutter or stammer			70. Sensitivity to chemicals, dust, sunlight, etc.
						16. Frequent, severe, or migraine headaches			71. Learning disabilities or speech problems
						17. Fainting or dizzy spells			72. Been refused employment or been unable to hold a job or stay in school because of:
						18. Periods of unconsciousness			
						19. Head injury or skull fracture			
						20. Epilepsy, seizures or convulsions			a. Inability to perform certain movements?
						21. Loss of memory (amnesia)			b. Inability to assume certain positions?
						22. Depression, anxiety, excessive worry, or nervousness			c. Other medical reasons?
						23. Any mental condition or illness			73. Been rejected for or discharged from military service because of physical, mental or other reasons?
						24. Frequent trouble sleeping			74. Been denied or rated up for life insurance?
						25. Hearing loss			75. Received or applied for pension or compensation for existing disability?
						26. Ear, nose, or throat trouble			76. Had or been advised to have, any surgical operations?
						27. Sinusitis or sinus trouble			77. Consulted, or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?
						28. Hay fever or allergic rhinitis			78. Had any injury or illness other than those already noted?
						29. Tooth/gum trouble, or current orthodontics			79. Been treated for a female disorder, painful periods, or cramps
						30. Thyroid trouble			
						31. Chronic cough or lung disease			
						32. Asthma or wheezing			80. Had a change in menstrual pattern
						33. Unusual shortness of breath			81. Are you now pregnant?
						34. Pain or pressure in chest			82. Date of last menstrual period (YYYYMMDD)
						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			

**83. REMARKS. Applicant use only.** Every "yes" response in items 7 through 81 must be explained in the space provided. Give specific dates and details including names of physicians and hospitals or clinics and the current status of the condition. If additional space is required, 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 of processing my application for this employment or service.

**TYPED OR PRINTED NAME OF EXAMINEE/APPLICANT**

**SIGNATURE OF EXAMINEE/APPLICANT**

**DATE SIGNED**  
(YYYYMMDD)

**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 significant findings here. If additional space is required, continue on a separate sheet and attach to this form.

**86. EXAMINER**

**TYPED OR PRINTED NAME OF EXAMINER**

**SIGNATURE OF EXAMINER**

**DATE SIGNED**  
(YYYYMMDD)

**87. NUMBER OF ATTACHED SHEETS**