U.S. Coast Guard - Scientific Mission Personnel Data Sheet - MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application

Mission Number:
TODAY'S DATE (YYYYMMDD):
SOCIAL SECURITY NUMBER:

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)
Next of Kin (Last Name, First Name, MI):

HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)
Next of Kin Address:

HOME TELEPHONE (Include Area Code)
Next of Kin Telephone:

Date of Birth:
Place of Birth:
Race/Nationality:
Native Language
Education Level:
Marital Status:

Citizenship:
- [ ] Native
- [ ] Naturalized
- [ ] Alien

Family Doctor:
Address:
Telephone No:

Maritime Rating:
Years of Maritime Service:

X History of Family Illness: Check if there is any history in your family of:

- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] High Blood Fats
- [ ] Psychiatric Illness
- [ ] Stroke
- [ ] Obesity
- [ ] Allergy
- [ ] Gout
- [ ] Jaundice
- [ ] Asthma
- [ ] Alcoholism
- [ ] Tuberculosis
- [ ] Heart Trouble
- [ ] Easy Bleeding
- [ ] Cancer of: ____
- [ ] Other: ____

Present Health:
- [ ] Excellent
- [ ] Good
- [ ] Fair/Poor

Height (in): ____
Usual Weight (lbs): ____
Usual Blood Pressure: ____
Hair Color: ____
Eye Color: ____

CURRENT MEDICATIONS (Prescription and Over-the-counter)

Date of last physical: ____
Date of last hospitalization: ____
Number of Days ____

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
Tuberculosis	○	○
Lived with someone who had tuberculosis	○	○
Coughed up blood	○	○
Asthma or any breathing problems related to exercise, weather, pollens, etc	○	○
Shortness of breath	○	○
Bronchitis	○	○
Wheezing or problems with wheezing	○	○
Been prescribed or used an inhaler	○	○
A chronic cough or cough at night	○	○
Sinusitis	○	○
Hay fever	○	○
Chronic or frequent colds	○	○
Severe tooth or gum trouble	○	○
Thyroid trouble or goiter	○	○
Eye disorder or trouble	○	○
Ear, nose, or throat trouble	○	○
Loss of vision in either eye	○	○
Worn contact lenses or glasses	○	○
A hearing loss or wear a hearing aid	○	○
Surgery to correct vision (RK, PRK, LASIK, etc.)	○	○
Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	○	○
Arthritis, rheumatism, or bursitis	○	○
Recurrent back pain or any back problem	○	○
Numbness or tingling	○	○
Loss of finger or toe	○	○

(Continued)	YES	NO
Foot trouble (e.g., pain, corns, bunions, etc.)	○	○
Impaired use of arms, legs, hands, or feet	○	○
Swollen or painful joint(s)	○	○
Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	○	○
Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
Bone, joint, or other deformity	○	○
Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
Broken bone(s) (cracked or fractured)	○	○
Frequent indigestion or heartburn	○	○
Stomach, liver, intestinal trouble, or ulcer	○	○
Gall bladder trouble or gallstones	○	○
Jaundice or hepatitis (liver disease)	○	○
Rupture/hernia	○	○
Rectal disease, hemorrhoids or blood from the rectum	○	○
Skin diseases (e.g. acne, eczema, psoriasis, etc.)	○	○
Frequent or painful urination	○	○
High or low blood sugar	○	○
Kidney stone or blood in urine	○	○
Sugar or protein in urine	○	○
Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	○	○
Adverse reaction to serum, food, insect stings or medicine	○	○
Recent unexplained gain or loss of weight	○	○
Currently in good health (If no, explain in Item 29 on Page 2.)	○	○
Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
Dizziness or fainting spells	○	○
Frequent or severe headache	○	○
A head injury, memory loss or amnesia	○	○
Paralysis	○	○
Seizures, convulsions, epilepsy or fits	○	○
Car, train, sea, or air sickness	○	○
A period of unconsciousness or concussion	○	○
Meningitis, encephalitis, or other neurological problems	○	○
Rheumatic fever	○	○
Prolonged bleeding (as after an injury or tooth extraction, etc.)	○	○
Pain or pressure in the chest	○	○
Palpitation, pounding heart or abnormal heartbeat	○	○
Heart trouble or murmur	○	○
High or low blood pressure	○	○
Nervous trouble of any sort (anxiety or panic attacks)	○	○
Habitual stammering or stuttering	○	○
Loss of memory or amnesia, or neurological symptoms	○	○
Frequent trouble sleeping	○	○
Received counseling of any type	○	○
Depression or excessive worry	○	○
Been evaluated or treated for a mental condition	○	○
Attempted suicide	○	○
Used illegal drugs or abused prescription drugs	○	○

Please explain in additional comments if "Yes" is chosen	Yes	No
Do you take non-perscription drugs routinely?	○	○
Do you take perscription drugs routinely?	○	○
Do you use recreational drugs?	○	○
Are you under the care of a physician now?	○	○

	YES	NO
Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons (If yes, give reasons.)	○	○
Have you ever been treated in an Emergency Room? (If yes, for what?)	○	○
Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	○	○
Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	○	○
Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	○	○
Have you ever been denied life insurance?	○	○

Have you had any of the following immunizations? Mon/Day/Year (ex. 3/17/03)

	Yes	No	Unsure	Date		Yes	No	Unsure	Date
Tetanus					Yellow Fever				
Smallpox					Typhus				
Typhoid					Gamma Globulin				
Plague					Diphtheria				
BCG (TB)					Malaria				
Cholera					Other				

Additional Comments: