

OHIO MILITARY RESERVE

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MI:		2. SOCIAL SECURITY OR IDENTIFICATION NO.	
3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)		4. POSITION (title, grade)	
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	

8. STATEMENT OF EXAMINEES PRESENT HEALTH AND MEDICATIONS CURRENTLY USED

9. HAVE YOU EVER (Please check each item)			10. DO YOU (Please check each item)		
YES	NO	(Check each item)	YES	NO	(Check each item)
<input type="checkbox"/>	<input type="checkbox"/>	Lived with anyone who had tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses or contact lenses
<input type="checkbox"/>	<input type="checkbox"/>	Coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>	Have vision in both eyes
<input type="checkbox"/>	<input type="checkbox"/>	Bled excessively after injury or tooth extraction	<input type="checkbox"/>	<input type="checkbox"/>	Wear a hearing aid
<input type="checkbox"/>	<input type="checkbox"/>	Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	Stutter or stammer habitually
<input type="checkbox"/>	<input type="checkbox"/>	Been a sleepwalker	<input type="checkbox"/>	<input type="checkbox"/>	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE NOW (Please check at left of each item)											
YES	NO	DONT KNOW	(Check each item)	YES	NO	DONT KNOW	(Check each item)	YES	NO	DONT KNOW	(Check each item)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever, erysipelas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Trick" or locked knee
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver, or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or sever headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble or gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (Including Infantile)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or fits
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adverse reaction to serum, drug, or medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Car, train, sea or air sickness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, nose or throat trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent trouble sleeping
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, growth, cyst, cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or excessive worry
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rupture/hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory or amnesia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe tooth or gum trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Piles or rectal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous trouble of any sort
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periods of unconsciousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting since age 12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar or albumin in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VD-Syphilis, gonorrhea, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent gain or loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism or Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone, joint or other deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lameness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of finger or toe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation or pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful or "trick" shoulder or elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

12. WHAT IS YOUR USUAL OCCUPATION?

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT								
		13. Have you been refused employment or been unable to hold a job or stay in school because of:								
		A. Sensitivity to chemicals, dust, sun light, etc.								
		B. Inability to perform certain motions.								
		C. Inability to assume certain positions.								
		D. Other medical reasons (if yes, give reasons)								
		14. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)								
		15. Have you ever been denied life insurance? (If yes, state reason and give details.)								
		16. Have you had, or have you been advised to have any operations? (If yes, describe and give age at which occurred.)								
		17. 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.)								
		18. Have you ever had any illness or injury other than those already noted? (If yes, specifically when, where, and give details.)								
		19. 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.)								
		20. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give, date and reason for rejection.)								
		21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)								
		22. Have you ever received, is there pending or have you applied for pension or compensation for existing disability? (If yes, specify what kind granted by whom, and what amount, when, why.)								
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 doctors, hospitals, or clinics mentioned above to furnish the OHIO MILITARY RESERVE a complete transcript of my medical record for purposes of processing my application for this employment or service.										
TYPED OR PRINTED NAME OF APPLICANT:					SIGNATURE:					
23. ADDITIONAL COMMENTS:										
24. HEIGHT		25. WEIGHT		26. COLOR HAIR		27. COLOR EYES		28. BUILD: (CHECK ONE)		
								A. SLENDER		
								B. MEDIUM		
								C. HEAVY		
29. TEMPERATURE:			30. BLOOD PRESSURE: (Arm at Heart Level)			31. PULSE: (Arm at Heart Level)				
32. SITTING		33. RECUMBENT:		34. STANDING (3 MIN)		35. SITTING		36. AFTER EXERCISE	37. 2 MIN AFTER	38. RECUMBENT
39. RESPIRATION:			40. BLOOD TYPE:			41. RELIGION:				
42. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER:			43. DATE:		44. SIGNATURE:			45. NUMBER OF ATTACHED SHEETS:		