							NO. OF ATTACHED SHEETS:					
MEDICAL RECORD RE				REPORT	EPORT OF MEDICAL HISTORY				DATE OF EXAM			
NOTE: This information is f	or official	and m	nedically	-confidenti	al use only and will	not be	releas	sed to ur	nauthorized persons			
NAME OF PATIENT(Last, first, middle)				2. IDENTIFICATION NUMBER				3. GRADE				
				1								
4a. HOME STREET ADDRESS(Street, City, State, ZIP)			\ 5 E	XAMINING FACILITY	/							
4a. HUME STREET ADDRESS(Street, City, State, ZIP)				/ P. L.	5. EXAMINING FACILITY							
				1								
4b. CITY 4c.	STATE	ld 7	IP CODE									
40. Ott 1	SIAIL	7 u. 2	IF CODE	·								
		1										
C DUDDOCE OF EVANINAT	201							 				
6. PURPOSE OF EXAMINAT	ION											
7 CTATEMEN	IT OF BAT	CIC NIT'	e porce	NIT LIFALT	LI AND MEDICATIO	NG OU	DDCN	ELV LICE				
a. PRESENT HEALTH	II OF PA	IENI	5 PRESI	NI HEALI	LTH AND MEDICATIONS CURRENTLY USE b. CURRENT MEDICATION			REGULAR OR INTERM.				
a. I NEOEMI HEALIN					D. OORKEIV	· WILDI	OATIO		REGOLAR OR IIV	Lat XIVI.		
c. ALLERGIES(Include inse	ect bites/s	tings a	nd comm	on foods)								
					d. HEIGHT				e. WEIGHT			
					d. HEIGH				e. WEIGHT			
					1							
- BATISHTIS COOLINATION					- ADE VOIL () .							
8. PATIENT'S OCCUPATION	ı				9. ARE YOU (check	(one)						
					☐ RIGHT HANDE	D			☐ LEFT HANDED			
				10. PA	ST/CURRENT MED		STOR	Y		-		
CHECK EACH ITEM	YES	NO	DON'T	CHEC	K EACH ITEM	YES	NO	DON'T	CHECK EACH ITEM	YES	NO	DON'T
Unionhald against with		-	KNOW	Chadasas	of hungah	-	-	KNOW	Dana jajut au athau dafarmitu	1		KNOW
Household contact with anyone with tuberculosis		+-		Shortness of breath Pain or pressure in chest		 			Bone, joint or other deformity Loss of finger or toe	1 1		
Tuberculosis or positive TB to	est	+	 	Chronic cough		 			Painful or "trick" shoulder	 		
Blood in sputum or when				Palpitation or pounding heart		1			or elbow			
coughing				Heart trouble			<u> </u>		Recurrent back pain or any	i		
Excessive bleeding after injur	у	ļ		High or low blood pressure Cramps in your legs			<u> </u>		back injury	1		
or dental work		+			 			Trick" or locked knee	1			
Suicide attempt or plans Sleepwalking		+		Frequent in Stomach, li	 	 		Foot trouble Nerve injury	++			
Wear corrective lenses		+			r trouble or	 	 		Paralysis (including infantile)	+ + 1		
Eye surgery to correct vision				gallstones		ļ			Epilepsy or seizure			
Lack vision in either eye				Jaundice or					Car, train, sea or air sickness			
Wear a hearing aid		-	_	Broken bon		ļ	ļ		Frequent trouble sleeping	-		
Stutter or stammer Wear a brace or back suppor		+		Adverse rea Skin diseas	action to medicine	1	1		Depression or excessive worry			<u> </u>
Scarlet fever	· -	+-	 		wth, cyst, cancer	 	 	-	Loss of memory or amnesia Nervous trouble of any sort	+		
Rheumatic fever		+-	 	Hernia	wui, cysi, cancei	<u> </u>	+-	<u> </u>	Periods of unconsciousness	1		
Swollen or painful joints		†	†		s or rectal disease	<u> </u>	—		Parent/sibling with diabetes,	1 1		
Frequent or severe headache	es			Frequent or	r painful urination				cancer, stroke or heart disease			
Dizziness or fainting spells					since age 12				K-ray or other radiation therapy			
Eye trouble		1			ne or blood in urine	<u> </u>	 		Chemotherapy	\sqcup		<u> </u>
Hearing loss Recurrent ear infections		+	1	 	bumin in urine	 	 		Asbestos or toxic chemical			
Chronic or frequent colds		+	 		insmitted diseases n or loss of weight				exposure Plate, pin or rod in any bone	 		
Severe tooth or gum trouble		\dagger	†		rder (anorexia,	†	†	<u> </u>	Easy fatigability	╅		
Sinusitis			1	bulimia, etc					Been told to cut down or	1 1		
Hay fever or allergic rhinitis			L		neumatism, or	T	T		criticized for alcohol use			
Head injury				Bursitis		ļ.,		L	Used illegal substances			
Asthma		1		Thyroid trou]	1		Used tobacco	1		L	

CHECK FACH ITEM YES NO DON'T DATE OF LAST PAP SMEAR MAMMORAM Treated for a female disorder Change in menistrual pattern CHECK EACH ITEM. IF "YES EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER 12. Have you ever been related employment or been unable to hold a job or stay in school because of: a. Sensithly to chemicals, dust, surlight, etc. b. Inability to perform certain motions c. Other medical reasons (if yes, dive reasons) 13. Have you ever been related in a mental condition? (if yes, specify when, where, and give details) 14. Have you ever been related to a mental condition? (if yes, specify when, where, and give details) 15. Have you have been chemical file insurance? (if yes, state reason and give details) 16. Have you seve been related to in any type of inclains and or discovered the formation of doctor and complete address of fhospital. 17. Have you consided or been treated by clinics, physicians, healers, or other practitioners within the last 5 years for other than minor illnesses (if yes, give date and complete address of doctor, hospital, clinic and details) 18. Have you ever been related for military service because of physical, mental or other reasons? (if yes, give date and treated by clinics, physicians, healers, or other reasons? (if yes, give date and treated by clinics, physicians, healers, or other practitioners within the last 5 years for other than honorable, chinic and details) 18. Have you ever been related for military service because of physical mental or other reasons? (if yes, give date and treated your complete address of physical mental or other reasons? (if yes, give date and treated your details) 19. Have you ever been related or convicted of a crime, and the properties of the properties of doctors and physical mental or other reasons? (if yes, give date, reason, and you ever applied for pension or compensation for existing disability? (if yes, give yea, where and how disappased) 20. Have you ever been related or convicted of a crime, and the properties of t	CHECK EACH ITEM Treated for a female disorder Change in menstrual pattern CHECK EACH ITEM. IF "YES EXPLAN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER 11. Have you ever been refused employment or been unable to hold a job or stay in school because of a. Semativity to chemicals, dust, surlight, etc. 1. Inability to perform certain motions C. Other medical reasons (if yes, oive reasons) 1. Have you ever been interest of a mental condition? (If yes, specify when, where, and give details) 1. Have you ever been dended life insurance? (If yes, state reason and give details) 1. Have you ever been dended life insurance? (If yes, state reason and give details) 1. Have you ever been dended life insurance? (If yes, state reason and give details) 1. Have you ever been and general in any type of hospital? (If complete address of hospital) 1. Have you ever been enged for military service because of physical, mental or other reasons? (If yes, give date and reason for rejection) 1. Have you ever been length of military service because of physical, mental or other reasons? (If yes, give date and reason for rejection) 1. Have you ever been length of or military service because of physical, mental or other reasons? (If yes, give date and reason for rejection) 1. Have you ever been rejected for military service because of physical, mental or other reasons? (If yes, give date and reason for rejection) 1. Have you ever been rejected for military service because of physical, mental or other reasons? (If yes, give date and reason for rejection) 1. Have you ever been rejected for military service because of physical, mental or other reasons? (If yes, give date and reason for rejection) 1. Have you ever been rejected for military service because of physical, mental or other reasons? (If yes, give date and reason for rejection) 1. Have you ever been rejected for military service because of physical, mental or other reasons? (If yes, give date and yes you have you have been rejected for military service beca				11 EEMA	I EC ON! V			
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