Personal Medical Data Form

1. Name: Last, First, MI	2. SSN:	3. Age:	4. Sex:	5. Rank	6. Unit:

7. Person to notify in case of emergency and telephone number:

( )

8. Present Health:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

9. List All Medication Currently Being Used
(Name and Dosage)

10. Do You Now or Have Had the Following: (Check all that apply)

- ☐ High or low Blood Pressure
- ☐ Bone, Joint or other Deformity
- ☐ Frequent or Severe Headache
- ☐ Painful or "Trick" Shoulder / Elbow
- ☐ Lock or "Trick" Knee
- ☐ Bowel or Stomach Problems
- ☐ Arthritis, Rheumatism or Bursitis
- ☐ Swollen or Painful Joints
- ☐ Dizziness or Fainting Spells
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Liver Problems
- ☐ Recurring Back Pain
- ☐ Shortness of Breath
- ☐ Gall Bladder Problems
- ☐ Hernia or Rupture
- ☐ Ear, Nose and Throat Trouble
- ☐ Bleeding Tendency
- ☐ Thyroid Problems
- ☐ Epilepsy or Fits
- ☐ Foot Trouble
- ☐ Heart Trouble
- ☐ Hearing Loss
- ☐ Eye Trouble
- ☐ Epilepsy or Fits
- ☐ Skin Disease
- ☐ Dental Problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Other _____

11. If you Checked Any of the Above Please Give Details:

12. List Any Allergies and Your Reaction:
(Including Medicines)

13. Do You Wear Glasses or Contacts? ☐ Yes ☐ No

14. Do You Wear a Hearing Aid? ☐ Yes ☐ No

15. Do You Wear a Brace or Back Support? ☐ Yes ☐ No

16. Do You Have Any Prosthesis? ☐ Yes ☐ No

17 Do You Wear Dentures or Partials? ☐ Yes ☐ No

18. List Any Other Illnesses, Injuries, Operations, or Other Problems Not List Above:
(Give Details)