New York Naval Militia
(NYNM)

REPORT OF MEDICAL HISTORY

FOR OFFICIAL USE ONLY
NYNM Form 93
(REV 08/11)

PRIVACY ADVISORY STATEMENT

NEW YORK NAVAL MILITIA

Health and Medical Personal Information

AUTHORITY FOR COLLECTION OF PERSONAL INFORMATION: Personal Privacy Protection Law of New York State; Privacy Act of 1974, 5 U.S. Code, sections 552-522a.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMAITON: The requested information is mandatory for New York Naval Militia (NYNM) members to insure that: (1) medical record information is accurate for the individual member; and (2) to document all active duty medical incidents in view of future rights and benefits. If the requested information is not furnished, the NYNM member will not be considered for assignment for routine or emergency state active duty. If a NYNM member currently serving on routine or emergency state active duty declines to provide the requested information, the NYNM member's assignment to routine or emergency state active duty may be terminated.

ROUTINE USES: This all inclusive Privacy Act Statement will apply to all requests for personal information made by the New York Naval Militia and applicable health care providers, or for medical treatment purposes. It will become part of your New York Naval Militia service record. The intended use is in order to maintain a rapid recall capability, emergency notification, and to facilitate and document your health care.

PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED: The primary use of this information is to identify NYNM members who are physically capable of conducting routine and/or arduous tasks that may arise during the performance of state active duty. This form provides you the advice required by the New York State Personal Privacy Act and the federal Privacy Act of 1974.

THIS FORM IS NOT A CONSENT FORM TO RELEASE PERSONAL INFORMATION PERTAINING TO YOU TO AGENCIES AND ENTITIES OUTSIDE OF THE NEW YORK STATE DIVISION OF MILITARY AND NAVAL AFFAIRS AND THE JOINT FORCES OF THE NEW YORK STATE ORGANIZED MILITIA.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

_____ _____

Signature of NYNM member Date

_____

Printed name and grade/rank of NYNM member

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NOTICE

The information requested below is required to provide the medical examiner an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the New York Naval Militia. Also this information will be provided to medical examiners in case of injury or illness. **If taking medications at time of application, list in Block 6.**

THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE. You are encouraged to consult your private medical provider regarding past illnesses.

1. UNIT INFORMATION

1a. Unit Name	**1b.** NYNM Region

2. PERSONAL INFORMATION

2a. Last Name	**2b.** First Name	**2c.** MI	**2d.** Blank

2e. Age	**2f.** Date of Birth (DD MMM YY)	**2g.** Sex ☐ Male ☐ Female	**2h.** Emergency Person Contact Name and Phone Number

2i. Home Address	**2j.** City

2k. State	**2l.** Zip Code + 4	**2m.** Home Phone	**2n.** Date of Physical Examination (DD MMM YY)

3. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 6: explain treatment to return member to medically fit for duty)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	**YES**	**NO**		**YES**	**NO**
3a. Tuberculosis or live with someone with tuberculosis	☐	☐	**3m.** Head injury or concussion	☐	☐
3b. Chronic or recurrent abdominal or stomach pain	☐	☐	**3n.** Seizures, convulsions, epilepsy, or fits	☐	☐
3c. Asthma or breathing problems related to exercise, pollen, etc.	☐	☐	**3o.** Car, train, sea, and/or air sickness	☐	☐
3d. Been prescribed or use an inhaler	☐	☐	**3p.** A period of unconsciousness	☐	☐
3e. Loss of vision in either eye	☐	☐	**3q.** Heart trouble or murmur	☐	☐
3f. Loss of hearing or wear a hearing aid	☐	☐	**3r.** Received counseling for emotional or behavior disorder	☐	☐
3g. Impaired use of arms, legs, hands, feet	☐	☐	**3s.** Eating disorder (bulimia, anorexia)	☐	☐
3h. Knee problems	☐	☐	**3t.** Sleepwalking	☐	☐
3i. Broken bones(s) (cracked or fractured)	☐	☐	**3u.** Frequent or severe headaches	☐	☐
3j. Diabetes	☐	☐	**3v.** Been hospitalized *(if yes, why, when, where)*	☐	☐
3k. Anemia (including sickle cell)	☐	☐	**3w.** Any illness or injury not mentioned above *(if yes, explain)*	☐	☐
3l. Dizziness or fainting spells (including after exercise)	☐	☐	**3x.** Advised to avoid certain physical activities *(if yes, explain)*	☐	☐

4. IMMUNIZATION RECORDS

IMMUNIZATIONS	Month/Year Given		Month/Year Given		Month/Year Given
Tetanus	_____/_____	Mumps	_____/_____	Tdap	_____/_____
Diptheria	_____/_____	Rubella	_____/_____	Hepatitis A	_____/_____
Pertussis	_____/_____	Polio	_____/_____	Hepatitis B	_____/_____
Measles	_____/_____	Chicken Pox	_____/_____	TB/PPD	_____/_____
Small Pox	_____/_____	Influenza	_____/_____	Anthrax	_____/_____

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5. ALLERGIES (Mark each item "YES" or "NO" Every item marked yes must be fully explained in block 5i)

DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:	YES	NO		YES	NO
5a. Bee or Wasp Sting	☐	☐	**5e.** Latex	☐	☐
5b. Hay Fever or seasonal allergies	☐	☐	**5f.** Any drug, E-mycin antibiotic, or sulfa allergies, list in Block 5i	☐	☐
5c. Insect Bites	☐	☐	**5g.** Other Allergies, list in Block 6	☐	☐
5d. Iodine/seafood	☐	☐	**5h.** Food allergies, list in Block 6	☐	☐

5i. Describe the allergic reaction and what condition occurs:

6. Remarks (Please include comments as required by Block 3. Also provide any other medical history that you or your physician deems important.)

List all current medications, including over-the-counter medications, vitamins, and supplements;

Social History:

Tobacco Use: Number of packs or dips per day: _____

Alcohol Use: Number of drinks per week (on average): _____

List all current medical restrictions:

Have there been any significant changes in your health since your last medical examination: ☐ NO ☐ YES. If YES, please describe:

7. AUTHORIZATON AND RELEASE

I certify that to the best of my knowledge the information provided is true and accurate and that I have disclosed all pertinent medical history.

8a. Member Name (Type or Print)	**8b.** Signature	**8c.** Date (DD MMM YY)