

										NO. OF ATTACHED SHEETS: <input type="text"/>			
										DATE OF EXAM <input type="text"/>			
MEDICAL RECORD					REPORT OF MEDICAL HISTORY								
NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons													
1. NAME OF PATIENT (<i>Last, first, middle</i>) <input type="text"/>							2. IDENTIFICATION NUMBER <input type="text"/>			3. GRADE <input type="text"/>			
										MIDN			
4a. HOME STREET ADDRESS (<i>Street or RFD; City or Town; State; and ZIP Code</i>) <input type="text"/>							5. EXAMINING FACILITY <input type="text"/>						
4b. CITY <input type="text"/>			4c. STATE <input type="text"/>		4d. ZIP CODE <input type="text"/>								
6. PURPOSE OF EXAMINATION													
NROTC Entrance Application													
7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (<i>Use additional pages if necessary</i>)													
a. PRESENT HEALTH <input type="text"/>						b. CURRENT MEDICATION <input type="text"/>				REGULAR OR INTERM. <input type="text"/>			
c. ALLERGIES (<i>Include insect bites/stings and common foods</i>) <input type="text"/>													
						d. HEIGHT <input type="text"/>				e. WEIGHT <input type="text"/>			
8. PATIENT'S OCCUPATION <input type="text"/>						9. ARE YOU (<i>Check one</i>)							
STUDENT						<input type="checkbox"/> RIGHT HANDED				<input type="checkbox"/> LEFT HANDED			
10. PAST/CURRENT MEDICAL HISTORY													
CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW		
Household contact with anyone with tuberculosis				Shortness of breath				Thyroid trouble or goiter					
Tuberculosis or positive TB test				Pain or pressure in chest				Bone, joint or other deformity					
Blood in sputum or when coughing				Chronic cough				Loss of finger or toe					
Excessive bleeding after injury or dental work				Palpitation or pounding heart				Painful or "trick" shoulder or elbow					
Suicide attempt or plans				Heart trouble				Recurrent back pain or any back injury					
Sleepwalking				High or low blood pressure				"Trick" or locked knee					
Wear corrective lenses				Cramps in your legs				Foot trouble					
Eye surgery to correct vision				Frequent indigestion				Nerve Injury					
Lack vision in either eye				Stomach, liver or intestinal				Paralysis (<i>including infantile</i>)					
Wear a hearing aid				Gall bladder trouble or gallstones				Epilepsy or seizure					
Stutter or stammer				Jaundice or hepatitis				Car, train, sea or air sickness					
Wear a brace or back support				Broken bones				Frequent trouble sleeping					
Scarlet fever				Adverse reaction to medication				Depression or excessive worry					
Rheumatic fever				Skin diseases				Loss of memory or amnesia					
Swollen or painful joints				Tumor, growth, cyst, cancer				Nervous trouble of any sort					
Frequent or severe headaches				Hernia				Periods of unconsciousness					
Dizziness or fainting spells				Hemorrhoids or rectal disease				Parent/sibling with diabetes, cancer, stroke or heart disease					
Eye trouble				Frequent or painful urination				X-ray or other radiation therapy					
Hearing loss				Bed wetting since age 12				Chemotherapy					
Recurrent ear infections				Kidney stone or blood in urine				Asbestos or toxic chemical exposure					
Chronic or frequent colds				Sugar or albumin in urine				Plate, pin or rod in any bone					
Severe tooth or gum trouble				Sexually transmitted diseases				Easy fatigability					
Sinusitis				Recent gain or loss of weight				Been told to cut down or criticized for alcohol use					
Hay fever or allergic rhinitis				Eating disorder (anorexia bulimia, etc.)				Used illegal substances					
Head injury				Arthritis, Rheumatism, or				Used tobacco					
Asthma				Bursitis									
NSN 7540-00-181-8368 Previous edition not usable						STANDARD FORM 93 (Rev. Jun 96) Prescribed by ICMR/GSA FIRMR (41 CFR) 201-9.202-1							

11. FEMALES ONLY						
CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
Treated for a female disorder						
Change in menstrual pattern						
CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.						
ITEM	YES	NO				
12. 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 assume certain positions.						
d. Other medical reasons <i>(If yes, give reasons.)</i>						
13. Have you ever been treated for a mental condition? <i>(If yes, specify when, where, and give details.)</i>						
14. Have you ever been denied life insurance? <i>(If yes, state reason and give details.)</i>						
15. Have you had, or have you been advised to have, any operations? <i>(If yes, describe and give age at which occurred.)</i>						
16. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i>						
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i>						
18. Have you ever been rejected for military service because of physical, mental, or other reasons? <i>(If yes, give date and reason for rejection.)</i>						
19. Have you ever been discharged from military service because of physical, mental, or other reasons? <i>(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)</i>						
20. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i>						
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. <i>(If yes, provide details.)</i>						
22. Have you ever been diagnosed with a learning disability? <i>(If yes, give type, where, and how diagnosed.)</i>						
23. LIST ALL IMMUNIZATIONS RECEIVED						
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 Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.						
24a. TYPED OR PRINTED NAME OF EXAMINEE				24b. SIGNATURE		24c. DATE
NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."						
25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician shall comment on all positive answers in items 7 through 11. Physician may develop by interview any additional medical history he deemed important, and record any significant findings here.)</i>						
26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER				26b. SIGNATURE		26c. DATE
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