KEYPUNCH ON ALL CARDS, COL 1-6

DO NOT KEYPUNCH

KEYPUNCH ON ALL CARDS, COL 7-18

DO NOT KEYPUNCH

MEDICAL EXAMINATION FORM

| HEENT | | | | | | | | | | NECK | | | EXTREMITIES | | | | | | | BACK | | | | SKELETAL | | | | | NEUROLOGICAL | | | | | | | | | |

DO NOT KEYPUNCH

PREPLACEMENT MEDICAL EXAMINATION HISTORY

RACE: White Black Other_____

MARITAL STATUS: S M W D Sep.

NO. CHILDREN: _____

Temp. _____°F. Pulse_____/Mi

FAMILY HISTORY:

Father Living and well _____ Sick _____ Dead _____ Cause of Death _____ # Brothers Living ____ Dead __

Mother Living and well _____ Sick _____ Dead _____ Cause of Death _____ # Sisters Living ____ Dead __

Do you have any relatives ill or who have died with the following: (Include relationship)

Cancer _____ Heart trouble _____ Nervousness _____

Diabetes _____ Epilepsy _____ Strokes _____

Asthma _____ Tuberculosis _____

PERSONAL HISTORY: (Include dates)

Injuries _____

Illnesses _____

Operations _____

Hospital or sanitarium admissions _____

Heaviest weight _____lbs. 19 ____ Weight gain/loss within last year? _____ lbs. Reason_____

Work absence due to illness or injury during last 3 years? _____ Reason _____

Female disorders _____ Details _____

Female Applicants: Menstruation: Regular _____ Pain _____ # Days _____ Date last period began _____

Number of pregnancies _____ Number of miscarriages or abortions _____

Have you had or do you now have the following: (Number the "yes" answers and include details and dates under "Explanation"

Allergies		Poor appetite		Kidney trouble		Paralysis	
Hayfever		Chest pain		Bladder trouble		Diabetes	
Hives		Shortness of breath		Backache		Tuberculosis	
Asthma		Chronic cough		Back injury		Jaundice	
Ear trouble		Last chest x-ray date		Rheumatism		Skin disease	
Fainting		Blood spitting		Gout		Rupture	
Dizziness		Heart trouble		Broken bones		Auto accidents	
Headache		Last EKG date		Knee injuries			
Eye trouble		High blood pressure		Nervous breakdown			
Stomach trouble		Swelling of feet		Fits or convulsions			

Explanation:

SERVICE HISTORY: Branch _____ # Years _____ Type Discharge _____ Date Discharged _____

OCCUPATIONAL HISTORY:

Is this your first job? Yes _____ No _____. (If answer is "No," complete MRMS-5, OCCUPATIONAL HISTORY QUESTIONNAIRE.)

I hereby declare that my answers to the preceding medical questionnaire are complete and true to the best of my knowledge.

Nurse's Applicant's

BRF 0331