DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
REPORT OF MEDICAL HISTORY

OMB No. 0704-0396 OMB approval expires Nov 30, 2009

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

The p and r incluc (0704 displa	oublic n naintain ling sug -0396) ay a cui <b>ASF</b>	eporting burden for this colle ning the data needed, and c ggestions for reducing the bu . Respondents should be aw rently valid OMB control num DO NOT RETURN Y(	ction ( comple rden, are th ber.	of inform eting and to the D at notwi	nation is es d reviewing epartment d ithstanding <b>M TO TH</b>	timated the co of Defe any ot IF <b>∆F</b>	d to ave ollectior ense, E: her prov	erage 1 n of inf xecutiv vision (	5 minu ormatio e Serv of law,	ion vice , no	se per response, including the time for . Send comments regarding this burc es Directorate, Information Managemen o person shall be subject to any penalt ATION. RETURN COMPLET	review len es nt Divis y for fa	ving ins timate sion, 11 ailing to	structions, or any oth 155 Defens o comply v	search ner asp se Per vith a o	ning existing bect of this itagon, Was collection o	g data sources, gathe collection of informa shington, DC 20301-1 f information if it does 8034	ering tion, 155 not	
		ON DRIVE, SUITE 13															, 0034		
								PRI\	AC)	Y	ACT STATEMENT								
	AUTH	ORITY: Title 10, USC 13	33, 30	012, 50	31, 8013,	and E	Execut	tive O	rder 9	939	97.								
	<b>PRINCIPAL PURPOSE:</b> To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).																		
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		OSURE: Voluntary; how ty Number (SSN) is used							forma	atio	on will impede the selection proce	ess ar	id han	nper you	r cano	didacy. U	se of the Social		
1. NAME (Last, First, Middle Initial)							2. SOCIAL SECURITY NUMBER 3. 1			3. T	ELEPHONE NO. (Include area code)								
4. PURPOSE OF EXAMINATION 5. EXAMINATIO				FION	ON FACILITY OR EXAMINER AND ADDRESS (Include ZIP Co						Code)	e) 6. DATE OF EXAMINATION (YYYYMMDD)							
expla	ained i		on th	e back							VERED, OR PROCESSING E the item to the best of your ability.								
		OU EVER OR DO	YES	NO				YES	NO	1	DO YOU	0a	fvouv	vear cont	act lor	ses how	many days have the		
Y YES	OU N NO	OW USE ANY OF THE FOLLOWING:			Marijuana	a					8. Wear glasses					this exam		y	
		Amphetamines			Alcohol (					T	9. Wear contact lenses or		Less	ss than 3		3 - 20	21 or over		
		Barbiturates			frequency if any)	, treati	ment,				corneal eye retainers (If Yes, complete 9a.)		Type lens:			Hard	Soft		
		Cocaine			Chemical	Inhala	ants			1	0. HAVE YOU EVER HAD YOUR VIS				тног	OS OTHER	THAN STATED IN		
		Narcotic Drugs			Hallucino	gens				1	QUESTIONS 8 OR 9?	•		ED BY METHODS OTHER THAN STATED IN					
YES	NO	HAVE YOU EVER HAD OR	DO		W HAVE:	YES	NO					YES	NO						
		11. Eye trouble (exclude gl	asses	, contac	t lenses)			40. G	allblad	dd	er trouble or gallstones			66. Sleepwalking episodes after age 12					
		12. Have fluctuating vision						41. H	epatiti	tis	(yellow jaundice)				67. Easily fatigued				
		13. Have any allergies						42. H	emorr	rho	bids or rectal disease			68. Moti	on sic	kness (car	, train, sea, or air)		
		14. Take any medications	regul	arly				43. Black or bloody stools						69. X-ray or other radiation therapy					
		15. Stutter or stammer	-					44. F	requer	nt	or painful urination			70. Sensitivity to chemicals, dust, sunlight, e					
		16. Frequent, severe, or m	igrair	ne head	aches			45. B	ed we	ettir	ng after age 12			71. Learning disabilities or speech problems					
		17. Fainting or dizzy spells	s					46. B	lood, j	pro	otein, or sugar in urine	YES	NO	HAVE YOU EVER					
		18. Periods of unconsciou	Isnes	s				47. History of diabetes						72. Been refused employment or been una				e to	
		19. Head injury or skull fra	acture	•				48. K	idney	ste	one			hold a job or stay in school becaus					
		20. Epilepsy, seizures or o	onvu	Isions				49. Hernia or rupture						a. Inability to perform certain movements?					
		21. Loss of memory (amne	esia)					50. Any bone or joint problem, injuries, surgery b. Inability to assume ce					e certain positions?	,					
		22. Depression, anxiety, e		sive wo	rry, or						al treatment			c. Other medical reasons?					
		nervousness						51. S	teel pi	ins	s, plates, or staples in any bones						discharged from mil		
		23. Any mental condition	or illn	ess		l		52. W	lear a	bo	one or joint brace or support				ice be ons?	cause of p	hysical, mental or o	tner	
		24. Frequent trouble sleep	oing					53. B	ack pa	ain	n or trouble			74. Beer	n deni	ed or rated	l up for life insuranc	e?	
		25. Hearing loss		-				54. P	aralys	sis	or weakness						for pension or		
		26. Ear, nose, or throat tro	ouble					55. F	oot tro	out	ble/use orthotics			com	pensa	tion for ex	isting disability?		
		27. Sinusitis or sinus trou	ble					56. R	56. Rheumatic fever					76. Had or been advised to have, any surgic			al		
		28. Hay fever or allergic rh	ninitis					57. T	ubercu	ulc	osis or positive TB test				rations				
		29. Tooth/gum trouble, or	curre	nt ortho	odontics	l		-			transmitted disease (syphilis,			77. Consulted, or been treated by clini hospitals, physicians, healers, or c					
		30. Thyroid trouble				L		g	gonorrhea, herpes)							er than minor illness	es?		
		31. Chronic cough or lung	) dise	ase		ļ			Skin conditions such as acne, psoriasis,					any in ady no		ess other than thos	e		
		32. Asthma or wheezing						n	and of	r TC	oot rashes, eczema, or dry skin				-				
		33. Unusual shortness of		h							eaction to vaccines, drugs,	YES	NO	FEMAL	LES C	ONLY (Cor	nplete Items 79 - 82)		
		34. Pain or pressure in ch								male disorder, painf	ul								
	35. Palpitation or pounding heart							61. Eating disorder					periods, or cramps						
36. Heart trouble or heart murmur						62. Recent gain or loss of weight 80. Had a change in mer				-									
37. High blood pressure						$\left  - \right $				e bleeding or easy bruising					ow pregna		וחנ		
	38. Coughed up or vomited blood								-	-	rowth, cyst, or cancer			82. Date	ot las	a menstru	al period (YYYYMME	(טל	
39. Stomach, liver, or intestinal trouble							65. C	onside	lere	ed or attempted suicide									

DD FORM 2492, MAR 2008

PREVIOUS EDITION IS OBSOLETE.

DoD Exception to SF93 approved by GSA/IRMS (8-91) Adobe Professional 7.0

83. REMARKS. Applicant use only. Every "yes" respon			
details including names of physicians and hospitals o separate sheet and attach to this form.	r clinics and the current status of the con	dition. If additional space is require	red, continue on a
84. CERTIFICATION. I certify that I have reviewed the for knowledge. I authorize any of the physicians, hospita medical record for purposes of processing my applica	ls, or clinics mentioned above to furnish	that it is true and complete to the l the Government a complete trans	best of my cript of my
knowledge. I authorize any of the physicians, hospita	Is, or clinics mentioned above to furnish tion for this employment or service.	that it is true and complete to the l the Government a complete trans	cript of my DATE SIGNED
knowledge. I authorize any of the physicians, hospita medical record for purposes of processing my applica	Is, or clinics mentioned above to furnish tion for this employment or service.	the Government a complete trans	cript of my
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