

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	<h1 style="margin: 0;">REPORT OF MEDICAL HISTORY</h1>	FOR OFFICIAL USE ONLY
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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 NSCC/NLCC training program. Also this information will be provided to medical examiners in case of injury or illness while participating in NSCC/NLCC activities.

THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE You are encouraged to consult your private physician regarding past illnesses. Proof of immunization for Polio, Measles, Mumps, Rubella and Diphtheria, Pertussis and Tetanus (DPT) plus Diphtheria and Tetanus (DT) booster must be provided.

1. UNIT INFORMATION	
1a. Unit Name	1b. Region

2. PERSONNEL INFORMATION			
2a. Last Name	2b. First Name	2c. MI	2d. Social Security Number
2e. Age	2f. Date of Birth (DD MMM YY)	2g. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	2h. Parent/Guardian Name (cadets only)
2i. Home Address	2j. City	2k. State	2l. Zip Code + 4
2m. Home Phone	2n. Date of Physical Examination (DD MMM YY)	2o. Location of Physical Examination	

3. CURRENT MEDICATION (<i>prescription and over-the-counter</i>)	4. ALLERGIES (including insect bites/stings, medicine, and other substances)
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5. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked yes must be fully explained in block 6)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO		YES	NO
5a. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	5n. Head injury, memory loss, or amnesia	<input type="checkbox"/>	<input type="checkbox"/>
5b. Lived with someone with Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	5o. Seizures, convulsions, epilepsy, or fits	<input type="checkbox"/>	<input type="checkbox"/>
5c. Asthma or breathing problems related to exercise, pollen, etc.	<input type="checkbox"/>	<input type="checkbox"/>	5p. Car, train, sea, and/or air sickness	<input type="checkbox"/>	<input type="checkbox"/>
5d. Been prescribed or use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	5q. A period of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
5e. Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	5r. Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>
5f. Loss of hearing or wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	5s. Received counseling for emotional or behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>
5g. Impaired use of arms, legs, hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	5t. Eating disorder (bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>
5h. Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	5u. Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
5i. Broken bones(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>	5v. Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
5j. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	5w. Been hospitalized (<i>if yes, why, when, where</i>)	<input type="checkbox"/>	<input type="checkbox"/>
5k. Anemia (including sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>	5x. Any illness or injury not mentioned above (<i>if yes, explain</i>)	<input type="checkbox"/>	<input type="checkbox"/>
5l. Dizziness or fainting spells (including after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	5y. Advised to avoid certain physical activities (<i>if yes, explain</i>)	<input type="checkbox"/>	<input type="checkbox"/>
5m. Frequent or sever headaches	<input type="checkbox"/>	<input type="checkbox"/>	5z. FEMALES ONLY: At what age did you begin menstrual cycle:		

6. EXPLANATION OF "YES" ANSWER(S) (<i>Describe answer(s), give date(s) of problems, name of doctor(s) and/or hospitals, treatment given and current medical status</i>)
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REPORT OF MEDICAL HISTORY

7. IMMUNIZATION RECORDS (Indicate date of last immunization and attach proof of immunization)

7a. Measles	7b. Rubella	7c. DPT/DT	7d. Mumps	7e. Polio	7f. TB Test	7g. Other
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8. REMARKS (please include and other medical history that you or your physician deems important)

9. ENDORSEMENT

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

9a. Parent/Guardian (for cadets) or Member Name (Type of Print)

9b. Signature

9c. Date (DD MMM YY)