

SIGNIFICANT MEDICAL HISTORY

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 U.S.C., Section 10204 and 10205, and E.O. 9397.

PRINCIPAL PURPOSE: To maintain essential records of Air Force Reservists, and identify specific personnel capabilities.

ROUTINE USES: Disclosure may be made to any Department of Defense component or, upon request, to other Federal, state, or local agencies in pursuit of their official duties and may be used for other lawful purposes including law enforcement and litigation.

DISCLOSURE: MANDATORY. Failure to respond could cause incorrect priority for recall in the event of national mobilization and is a violation of Federal law.

NAME (Please print)

SSN

Answering the following questions will assist the health care provider in evaluating your general health and worldwide qualification for continued military service.

1. Do you have a medical condition which you believe may limit your ability to be mobilized? (If so, please describe.)

2. Please check any of the following which you have, or have had.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Amputations | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Back Injuries/Conditions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Sex Change |
| <input type="checkbox"/> Any Heart Surgery | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes, diet controlled | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes, oral medication | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes, requiring insulin | <input type="checkbox"/> Parkinson's Disease | |

3. Are you presently, or have you been under the care of a physician during the past year? (If so, why?)

4. Are you presently taking any medicine or drugs? (If so, list them.)

5. Have you ever been seen by a psychiatrist, psychologist, or social worker? (If so, provide diagnosis.)

6. Remarks:

To the best of my knowledge, the above information is complete.

SIGNATURE

DATE (YYYYMMDD)

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