

NAVMED article 15-45 requires that all active duty Navy and Marine Corps officers undergo certain physical examinations during their period of active service. The purpose of this examination, among other things, is to detect disease processes in their incipiency, thereby permitting earlier therapy, and to maintain current medical data regarding the physical fitness of the officer concerned.

As part of this examination, the following questionnaire is to be completed by the officer at the time he takes the examination. This questionnaire is designed to assist the medical officers conducting the examination to determine whether any special investigations or procedures might be instituted in the interest of preserving the examinee's health.

Please answer each question. If you are unable to answer any of the questions, please circle the question and call it to the attention of the examining doctor.

YOUR AGE	THE FOLLOWING CONCERNS THE PERIOD BETWEEN YOUR LAST PHYSICAL EXAMINATION AND THIS ONE PLACE AN "X" IN THE APPROPRIATE COLUMN.						
1. HAVE YOU HAD-							
CARDIOVASCULAR:	NO	SELDOM	FREQUENT	GASTROINTESTINAL (CONTINUED):	NO	SELDOM	FREQUENT
SHORTNESS OF BREATH WITH EXERTION				DIARRHEA			
ANKLE SWELLING				BLOOD IN BOWEL MOVEMENT			
HIGH BLOOD PRESSURE				BLACK BOWEL MOVEMENT			
RAPID HEART BEAT				INCREASE APPETITE			
IRREGULAR HEART BEAT				INCREASED THIRST			
DIZZINESS				DECREASED APPETITE			
FAINTING SPELLS				NAUSEA AND VOMITING			
CHEST PAIN OR PRESSURE				DIFFICULTY SWALLOWING			
LEG CRAMPS				GENITOURINARY:			
RESPIRATORY:				BACK PAIN			
COUGH				FREQUENT URINATION			
COUGHED UP BLOOD				PAINFUL URINATION			
HOARSENESS				PAIN IN TESTICLES			
SORE THROATS				BLOODY OR OTHER DISCHARGE			
SNEEZING				LOSS OF SEXUAL POTENCY			
HAY FEVER				MUSCULO-SKELETAL:			
NOSE BLEEDS				ARTHRITIS			
CHEST PAIN				MUSCLE PAIN OR CRAMPS			
ASTHMA OR WHEEZING				PAINFUL JOINTS			
PNEUMONIA				LAMENESS			
GASTROINTESTINAL:				BACKACHES			
INDIGESTION				WEAKNESS			
ABDOMINAL PAIN OR CRAMPS				SKIN:			
CONSTIPATION				ULCERATIONS			
				ITCHING			
Name (Last, first & middle)		Date of birth		Branch of Service		Service and Social Security Number	

MISCELLANEOUS:	NO	SELDOM	FREQUENT	3. DOES YOUR FAMILY HAVE A HISTORY OF	YES	NO			
FEVER				DIABETES					
CHILLS				GOUT					
NIGHT SWEATS				HIGH BLOOD PRESSURE					
HEADACHES				HEART ATTACKS					
INSOMNIA				STROKES					
NERVOUSNESS				CANCER					
IRRITABILITY				4. WHAT MEDICATIONS DO YOU CURRENTLY TAKE?					
MORNING TIREDNESS				5. HAVE YOU BEEN HOSPITALIZED OR TREATED AT SICKCALL IN THE PAST YEAR FOR WHAT YOU WOULD CONSIDER A SIGNIFICANT CONDITION? IF SO, PLEASE LIST.					
EASY FATIGABILITY									
2. DO YOU HAVE OR HAVE YOU HAD RECENTLY?			YES				NO	6. ARE THERE OTHER FACTORS IN YOUR PHYSICAL CONDITION NOT ALREADY COVERED THAT YOU HAVE QUESTIONS ABOUT? WHAT?	
WEIGHT LOSS. HOW MUCH? ()									
WEIGHT GAIN. HOW MUCH? ()									
MEMORY DEFECT									
CHANGE IN HANDWRITING									
DIFFICULTY IN WALKING IN THE DARK									
BALANCE PROBLEMS									
NUMBNESS AND TINGLING IN EXTREMITIES									
HEARING LOSS									
RINGING IN EARS									
VISION CHANGE									
DOUBLE VISION									
EARACHES									
RUNNING EARS									
NEW SKIN GROWTHS									
CHANGE IN SKIN COLOR									
TENDENCY TO BLEED OR BRUISE EASILY									
ATHLETES FOOT									
YELLOW JAUNDICE									
HEAT INTOLERANCE									
COLD INTOLERANCE									
CHANGE IN SHOE OR HAT SIZE									
LYMPH NODE ENLARGEMENT									
TUBERCULOSIS EXPOSURE									
KINDEY STONES									
DO YOU USE TOBACCO PRODUCTS?									
TO WHAT EXTENT? _____									
HOW MANY YEARS? _____									
DO YOU USE ALCOHOL?									
TO WHAT EXTENT? _____									
HOW MANY YEARS? _____									

7. REMARKS:

DATE AND SIGNATURE