OHIO SPECIAL RESPONSE TEAM
REPORT OF MEDICAL EXAMINATION AND HISTORY

1. NAME (Last, First, MI)	2 DATE OF APPLICATION	3. DOB

5. HOME ADDRESS (Number, Street, City, State, ZIP Code)	6. FAMILY DOCTOR'S NAME ADDRESS AND PHONE NUMBER

7. MEDICATIONS CURRENTLY TAKING AND DOSAGE:

8. **HAVE YOU EVER (Check each item)**

YES	NO	(Check each item)	YES	NO	
		Lived with anyone who had tuberculosis			Any allergic reactions
		Coughed up blood			Diabetes
		Bled excessively after injury or tooth extraction			Any diagnosis of cancer
		Been rejected for, or discharged from, military service because of physical, mental, or other reasons			

9. **HAVE YOU EVER HAD OR DO YOU NOW HAVE (Check each item)**

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or stones				Paralysis (including infantile)
			Dizziness or fainting spells				Recurrent back pain				Epilepsy or fits
			Eye trouble				Jaundice or hepatitis				Car, train, air or sea sickness
			Ear, nose, or throat trouble				Adverse reaction to serum, drug,				Frequent trouble sleeping
			Hearing loss				or medicine				Depression or excessive worry
			Chronic or frequent colds				Broken bones				Loss of memory or amnesia
			Sinusitis				Tumor, growth, cyst, or cancer				Nervous trouble of any sort
			Hay fever				Rupture/hernia				Periods of unconsciousness
			Head injury				Piles or rectal disease				Sensitivity to dust, foods
			Skin diseases				Frequent or painful urination				Been treated for a mental-related
			Thyroid problem				Bed wetting since age 12				condition? If yes, give details.
			Tuberculosis				Kidney stone or blood in urine				Been a patient in any type of hos-
			Asthma				Sugar or albumin in urine				pital? If yes, give details and date.
			Shortness of breath				VD, syphilis, gonorrhea, etc.				
			Pain or pressure in chest				AIDS				
			Chronic cough				Recent gain or loss in weight				
			Palpitation or pounding heart				Arthritis, rheumatism or bursitis				10. **DO YOU (Check each item)**
			Heart trouble				Bone, joint or other deformity				Wear glasses or contact lenses
			High or low blood pressure				Lameness				Have vision in both eyes
							Loss of finger or toe				Have colorblindness
							Loss of hand, foot, or limb				Wear a hearing aid
							Painful; "trick" shoulder or elbow				Wear a brace or back support

11. LIST ANY ALLERGIES AND YOUR REACTION:

12. STATEMENT OF PAST MEDICAL HISTORY (not mentioned above). LIST OTHER ILLNESSES, INJURIES, OPERATIONS PERFORMED OR ADVISED.

13. IMMUNIZATION RECORD (Tetanus, diphtheria, polio, typhus, malaria, yellow fever, other; show last date of each)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above, or on accompanying documents related to the above, to furnish to the Ohio Special Response Team, or to appropriate medical authority, a complete transcript of my medical record for the purpose of processing my application to this Organization.

DATE ____________ SIGNATURE ____________