MEDICAL PHYSICAL FORM

Name:	Date of Birth:
Address:	
City:	State:	Zip:
Signature:	Date:

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FO LLOWING: (For each "yes" checked describe conditions in remarks)

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
○	○	a. frequent or severe headaches	○	○	g. heart trouble	○	○	m. nervous trouble of any sort	○	○	s. medical rejection from service
○	○	b. dizziness or fainting spells	○	○	h. high or low blood pressure	○	○	n. any drug or narcotic habit	○	○	t. admission to hospital
○	○	c. unconsciousness for any reason	○	○	i. stomach trouble	○	○	o. excessive drinking habit	○	○	u. rejection for life insurance
○	○	d. eye trouble except glasses	○	○	j. kidney stone or blood in urine	○	○	p. attempted suicide	○	○	v. record of traffic convictions
○	○	e. hay fever	○	○	k. sugar or albumin in urine	○	○	q. motion sickness requiring drugs	○	○	w. record of other convictions
○	○	f. asthma	○	○	l. epilepsy or fits	○	○	r. military medical discharge	○	○	x. other illnesses

REMARKS: (if no changes since last report, so state)

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MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS

Date	Name of Physician Consulted	Reason

SIGNATURE OF APPLICANT	DATE