

**MEDICAL HISTORY REPORT (EMPLOYEES/APPLICANTS)**

**U.S. DEPARTMENT OF JUSTICE  
 FEDERAL BUREAU OF PRISONS**

THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY PRIVILEGED USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

Examining Facility	Date of Examination
Name of Patient: (Last Name, First Name, Middle Name)	Social Security Number
Purpose of Examination	

Statement of your present health and any medications currently used:

Have you ever: (Please check each item)	Yes	No	Do you (Please check each item)	Yes	No
(1) Been treated for Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	(7) Wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
(2) Been treated for psychiatric condition?	<input type="checkbox"/>	<input type="checkbox"/>	(8) Have vision in both eyes?	<input type="checkbox"/>	<input type="checkbox"/>
(3) Been hospitalized for medical or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>	(9) Wear a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
(4) Been denied employment for medical /psychiatric reasons?	<input type="checkbox"/>	<input type="checkbox"/>	(10) Wear a back brace or back support?	<input type="checkbox"/>	<input type="checkbox"/>
(5) Been advised to have surgery that has not been done?	<input type="checkbox"/>	<input type="checkbox"/>	(11) Have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
(6) Applied for any disability compensation?	<input type="checkbox"/>	<input type="checkbox"/>	(12) Take prescription medications currently?	<input type="checkbox"/>	<input type="checkbox"/>

**HAVE YOU EVER HAD OR HAVE NOW:**

(Please check each item)	Yes	No	(Please check each item)	Yes	No	(Please check each item)	Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Bone disease	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Pressure in chest	<input type="checkbox"/>	<input type="checkbox"/>	Unstable joints	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Throat trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumor/Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>
Painful/Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Urinary trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy (females only)	<input type="checkbox"/>	<input type="checkbox"/>
Foot problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal menstrual cycle (females only)	<input type="checkbox"/>	<input type="checkbox"/>

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.

Typed or printed name of Examinee	Signature
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To be Completed by Reviewing Examiner

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Explain all the "Yes" Responses to questions on Front Page

Typed or printed name of Physician or Examiner	Signature	Date	Institution (Name & Address)
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