

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 incipency, 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			
				BLOOD IN BOWEL MOVEMENT			
ANKLE SWELLING				BLACK BOWEL MOVEMENT			
HIGH BLOOD PRESSURE				INCREASE APPETITE			
RAPID HEART BEAT				INCREASED THIRST			
IRREGULAR HEART BEAT				DECREASED APPETITE			
DIZZINESS				NAUSEA AND VOMITING			
FAINTING SPELLS				DIFFICULTY SWALLOWING			
CHEST PAIN OR PRESSURE				GENITOURINARY:			
LEG CRAMPS				BACK PAIN			
RESPIRATORY:				FREQUENT URINATION			
COUGH				PAINFUL URINATION			
COUGHED UP BLOOD				PAIN IN TESTICLES			
HOARSENESS				BLOODY OR OTHER DISCHARGE			
SORE THROATS				LOSS OF SEXUAL POTENCY			
SNEEZING				MUSCULO-SKELETAL:			
HAY FEVER				ARTHRITIS			
NOSE BLEEDS				MUSCLE PAIN OR CRAMPS			
CHEST PAIN				PAINFUL JOINTS			
ASTHMA OR WHEEZING				LAMENESS			
PNEUMONIA				BACKACHES			
GASTROINTESTINAL:				WEAKNESS			
INDIGESTION				SKIN:			
ABDOMINAL PAIN OR CRAMPS				ULCERATIONS			
CONSTIPATION				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						
EASY FATIGABILITY						
2. DO YOU HAVE OR HAVE YOU HAD RECENTLY?			YES	NO		
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? _____						
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.						
6. ARE THERE OTHER FACTORS IN YOUR PHYSICAL CONDITION NOT ALREADY COVERED THAT YOU HAVE QUESTIONS ABOUT? WHAT?						

7. REMARKS:

DATE AND SIGNATURE