# Annual Health Screening Form for HPSP, NCP, FAP and NADDS Participants

***Medical Questionnaire*: *Submit appropriate documentation for all "YES" answers.***

**1. Personal Information**

**Name:** **Rank:** **Phone:**
**E-Mail:** **Last four SSN:** **Grad Year:**
**Program: HPSP:** ☐ 1975 (Medical Corps) ☐ 1985 (Dental Corps) ☐ 1995 (Medical Service Corps)
☐ NCP ☐ FAP ☐ NADDS

**2. Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school or training?** ◯ YES ◯ NO
If yes, explain:

**3. Are you now, or have you been in the care of a Health Professional during the past 12 months?** ◯ YES ◯ NO
If yes, explain

**4. Have you been prescribed or taken any prescription medications in the past 12 months?** ◯ YES ◯ NO
If yes, please list PRESCRIBED medications and reasons for their use:

**5. Do you have any physical or psychological concerns which might restrict your performance on active duty or prevent you from coming on active duty?** ◯ YES ◯ NO
If yes, explain:

**6. Date of your last HIV test:**
HIV testing is required every two years. Please submit proof of testing and results if a new test was required.

**7. Current Height in Inches:** **Current Weight in Pounds:** **Age:** **Sex:**

**I certify that the information contained in this form is true and complete to the best of my knowledge. I understand that I may be asked to provide additional documentation for any "YES" answer(s).**

**Member's Signature:** **Date:**

PRIVACY ACT STATEMENT: Authority 44 USC 3101 and EQ 9397. Principal Purpose: College information. The SSN is used to positively identify student. Routine Use: Information used to manage HPSP/FAP/NCP/NADDS program students. Disclosure: Voluntary, however, failure to supply this information could result in suspension/termination of benefits (LWOP or separation).

Please return to the Medical Readiness and Records Department.
Email: OH@med.navy.mil Attn: Medical Records

REV 08/2011

Please provide the following information below:

Full Name: _____

Last 4 SSN: _____

Email address: _____

Current Mailing address: (Where you receive your personal mail)

Line 1 _____

Line 2 _____

City _____ State _____

Zip _____

Primary Phone #: _____ Cell (○); Home (○); Work (○)

Secondary Phone #: _____ Cell (○); Home (○); Work (○)

Member Signature: _____ Date: _____

Print Form

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