U.S. NAVAL SEA CADET CORPS
U.S. NAVY LEAGUE CADET CORPS

REPORT OF MEDICAL HISTORY

FOR OFFICIAL USE ONLY

NOTICE

The information requested below is required to provide the medical examiner an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the NSCC/NLCC training program. Also this information will be provided to medical examiners in case of injury or illness while participating in NSCC/NLCC activities.

THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE You are encouraged to consult your private physician regarding past illnesses. Proof of immunization for Polio, Measles, Mumps, Rubella and Diphtheria, Pertussis and Tetanus (DPT) plus Diphtheria and Tetanus (DT) booster must be provided.

1. UNIT INFORMATION

1a. Unit Name	**1b.** Region

2. PERSONNEL INFORMATION

2a. Last Name	**2b.** First Name	**2c.** MI	**2d.** Social Security Number

2e. Age	**2f.** Date of Birth (DD MMM YY)	**2g.** Sex ☐ Male ☐ Female	**2h.** Parent/Guardian Name (cadets only)

2i. Home Address	**2j.** City	**2k.** State	**2l.** Zip Code + 4

2m. Home Phone	**2n.** Date of Physical Examination (DD MMM YY)	**2o.** Location of Physical Examination

3. CURRENT MEDICATION *(prescription and over-the-counter)*	**4.** ALLERGIES (including insect bites/stings, medicine, and other substances)

5. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked yes must be fully explained in block 6)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO		YES	NO
5a. Tuberculosis	☐	☐	**5n.** Head injury, memory loss, or amnesia	☐	☐
5b. Lived with someone with Tuberculosis	☐	☐	**5o.** Seizures, convulsions, epilepsy, or fits	☐	☐
5c. Asthma or breathing problems related to exercise, pollen, etc.	☐	☐	**5p.** Car, train, sea, and/or air sickness	☐	☐
5d. Been prescribed or use an inhaler	☐	☐	**5q.** A period of unconsciousness	☐	☐
5e. Loss of vision in either eye	☐	☐	**5r.** Heart trouble or murmur	☐	☐
5f. Loss of hearing or wear a hearing aid	☐	☐	**5s.** Received counseling for emotional or behavior disorder	☐	☐
5g. Impaired use of arms, legs, hands, feet	☐	☐	**5t.** Eating disorder (bulimia, anorexia)	☐	☐
5h. Knee problems	☐	☐	**5u.** Sleepwalking	☐	☐
5i. Broken bones(s) (cracked or fractured)	☐	☐	**5v.** Bedwetting	☐	☐
5j. Diabetes	☐	☐	**5w.** Been hospitalized *(if yes, why, when, where)*	☐	☐
5k. Anemia (including sickle cell)	☐	☐	**5x.** Any illness or injury not mentioned above *(if yes, explain)*	☐	☐
5l. Dizziness or fainting spells (including after exercise)	☐	☐	**5y.** Advised to avoid certain physical activities *(if yes, explain)*	☐	☐
5m. Frequent or sever headaches	☐	☐	**5z. FEMALES ONLY:** At what age did you begin menstrual cycle:		

6. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problems, name of doctor(s) and/or hospitals, treatment given and current medical status)*

REPORT OF MEDICAL HISTORY

7. IMMUNIZATION RECORDS (Indicate date of last immunization and attach proof of immunization)

7a. Measles	**7b.** Rubella	**7c.** DPT/DT	**7d.** Mumps	**7e.** Polio	**7f.** TB Test	**7g.** Other

8. REMARKS (please include and other medical history that you or your physician deems important)

9. ENDORSEMENT

"I certify that to the best of my knowledge that the information provided is true and accurate and that I have disclosed all pertinent medical history"

9a. Parent/Guardian (for cadets) or Member Name (Type of Print)	**9b.** Signature	**9c.** Date (DD MMM YY)