

WASHINGTON WING MEDICAL INFORMATION

If form is not legible you may not be selected for the activity. This information is for Official Use Only and will not be released to unauthorized persons. Answer all questions as accurately as possible so that special activity staff can make themselves aware of any pre-existing medical problems or conditions and be alert to help you.

NAME: Last Name, First Name, Middle Initial			Date Joined CAP					
			Month:		Year:			
MAILING ADDRESS: (Number and Street)			UNIT CHARTER NUMBER					
			PCR-WA-					
CITY	STATE	ZIP CODE	HOME PHONE					
CAPID	CAP GRADE	DATE OF BIRTH		AGE				
		MM	DD	YYYY				
GENDER (circle) M - F	HEIGHT	WEIGHT	HAIR	EYES				
DO YOU CURRENTLY USE ANY MEDICATION? (Including eye drops & birth control pills) (Give the date and reason in the remarks section.)			<input type="checkbox"/> NO	<input type="checkbox"/> YES				
HAVE YOU HAD OR BEEN INVOLVED IN AN ACCIDENT IN THE PAST 2 YEARS? (Explain the extent of your injuries and treatment required in the remarks section.)			<input type="checkbox"/> NO	<input type="checkbox"/> YES				
HAVE YOU HAD OR HAVE NOW ANY OF THE FOLLOWING? (If yes is answered on any items, please explain why in the remarks section with dates and physician(s) consulted (if any). Items not specifically noted below having the potential to interfere with performance during the activity should be documented in the remarks section.)								
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Frequent or Severe Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Ear Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hay Fever
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Dizziness or Fainting Spells	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Rupture	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Attempted Suicide
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Unconsciousness for any reason	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heart Trouble	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Eye Trouble, Excluding Glasses	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Epilepsy or Fits	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Motion Sickness
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Stones or Blood in Urine	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chronic or recurring injuries			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sugar or Albumin in Urine	<input type="checkbox"/> No	<input type="checkbox"/> Yes	GIRLS ONLY—Menstrual Cramps			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	High or Low Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Positive TB Skin Test			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Other Illness or Accidents	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chronic Diseases (Diabetes or Bronchitis)			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stomach Trouble	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Any Drug or Narcotic Habit			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Admission to Hospital			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Rejection for Life Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Military Rejection or Medical Discharge			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Food Allergies (Explain)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Allergic Reaction to Bug Bites/Bee Stings (circle)			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seen a doctor in the last 5 years other than regular office visits or physicals (Explain)						
IMMUNIZATIONS								
FAMILY PHYSICIAN								
Name: _____								
Address: _____ Phone Number: _____								

