

STANDARD FORM NO. 104
 PREVIOUS EDITIONS ARE OBSOLETE
 PREPARED BY
 BUREAU OF THE BUDGET
 EXECUTIVE SECRETARIAT

REPORT OF MEDICAL HISTORY

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

1. LAST NAME—FIRST NAME—MIDDLE NAME		3. GRADE AND COMMENT OR POSITION		4. IDENTIFICATION NO.
[Redacted]		[Redacted]		[Redacted]
5. PURPOSE OF EXAMINATION			6. DATE OF EXAMINATION	
[Redacted]			[Redacted]	
7. SEX	8. RACE	9. MILITARY GRADE	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
M	White	6	1 1/2	[Redacted]
12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN		
[Redacted]	Mexico, D. F.	Mex. [Redacted] - Wife - Same as above.		
15. EXAMINING FACILITY OR EXAMINER'S ADDRESS				
66 WC-185 He - 6'3" (2/17/63)				

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. (Follow by description of past history, if complaints occur)

Health normal - feel fine - no complaints.

18. FAMILY HISTORY				19. HAS ANY BLIODE RELATION (Father, mother, sister, other)? (If none, so wife)		RELATION(S)
RELATION	AGE	STATE OF HEALTH	IF DEAD CAUSE OF DEATH	AGE AT DEATH	YES NO (Check each item)	
FATHER			Pneumonia	86	X	Sister
MOTHER			"	76	X	Mother
SPOUSE	46	Normal			X	
SISTERS	53	"			X	
	52		Tuberculosis	52	X	
CHILDREN	51	"			X	
	50		Combat W. W. II	33	X	
	22	Excellent			X	
	19	"			X	
	14	"			X	
	5	"			X	

20. HAVE YOU EVER HAD OR HAVE YOU NOW - (Put check at left of each item)								
YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
X		SCARLET FEVER, ERYSIPELAS	X		TUMOR, GROWTH, CYST, CANCER	X		"ROCK" OR LOCKED ANGLE
X		DIPHTHERIA	X		TUBERCULOSIS	X		FOOT TROUBLE
X		RHEUMATIC FEVER	X		SCALING SKIN (PSORIASIS)	X		NEURALGIA
X		SWOLLEN OR PAINFUL JOINTS	X		ASTHMA	X		PARALYSIS (ERIC. HISTORY)
X		MILKPS	X		SHORTNESS OF BREATH	X		EPILEPSY OR FITS
X		WHOOPING COUGH	X		PAIN OR PRESSURE IN CHEST	X		GAR, TRAIL, SEAL OR AIR SICKNESS
X		FREQUENT OR SEVERE HEADACHE	X		CHRONIC COUGH	X		FREQUENT TROUBLE SLEEPING
X		DOZINESS OR FADING SPELLS	X		PALPITATION OR POUNDING HEART	X		FREQUENT OR TERRIFYING NIGHTMARES
X		EYE TROUBLE	X		HIGH OR LOW BLOOD PRESSURE	X		DEPRESSION OR EXCESSIVE BERRY
X		EAR, NOSE OR THROAT TROUBLE	X		CRAMPS IN YOUR LEGS	X		LOSS OF MEMORY OR APATHY
X		PURRING EARS	X		FREQUENT INDIGESTION	X		BED WETTING
X		CHRONIC OR FREQUENT COLDS	X		STOMACH ULCER OR INTESTINAL TROUBLE	X		NEURALGIA TROUBLE OF ANY SORT
X		SEVERE TOOTH OR GUM TROUBLE	X		GALL BLADDER TROUBLE OR GALL STONES	X		ABUSE OF DRUGS OR NARCOTIC HABIT
X		SUNBURN	X		JAUNDICE	X		EXCESSIVE DRINKING HABIT
X		HAY FEVER	X		ANY REACTION TO SERUM, DRUG OR MEDICINE	X		ALCOHOLIC TENDENCIES

21. WERE YOU EVER (Check each item)	22. FEMALES ONLY - HAVE YOU EVER—	23. WHAT IS YOUR USUAL OCCUPATION?	24. AGE AT ONSET OF MENSTRUATION
X WORN GLASSES	X BEEN PREGNANT	Business Management	
X WORN AN ARTIFICIAL EYE	X HAD A VAGINAL DISCHARGE		
X WORN HEARING AIDS	X BEEN TREATED FOR A FEMALE DISORDER		
X STUTTERED OR STAMMERED	X HAD PAINFUL MENSTRUATION		
X WORN A BRACE OR BACK SUPPORT	X HAD IRREGULAR MENSTRUATION		
25. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS? 1	26. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS 14	27. DATE OF COL (CA) (CA 6000)	QUANTITY <input type="checkbox"/> normal <input type="checkbox"/> excessive <input type="checkbox"/> scanty

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YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF A. SENSITIVITY TO CHEMICALS, DUST, SMOKE, ETC.
	X	B. INABILITY TO PERFORM CERTAIN WORKS
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS
	X	D. OTHER MEDICAL REASONS (If yes, give reasons)
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (If yes, give details)
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (If yes, state reason and give details)
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (If yes, state reason and give details)
	X	32. HAVE YOU HAD OR WERE YOU EVER ADVISED TO HAVE ANY OPERATIONS? (If yes, describe and give age at which occurred)
	X	33. HAVE YOU EVER BEEN A PATIENT (compulsed or voluntary) IN A MENTAL HOSPITAL OR SANATORIUM? (If yes, specify when, where, w.v.v. and name of doctor, and complete address of hospital or clinic)
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (If yes, specify when, where, and give details)
X		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 3 YEARS? (If yes, give complete address of doctor, hospital, clinic, etc.)
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (If yes, which illnesses)
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (If yes, give date and reasons for rejection)
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (If yes, give date, reason, and type of discharge, whether honorable, other than honorable, for unfitness or unsuitability)
	X	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (If yes, specify what kind, granted by whom, and what amount, when, why)

Routine Check-Ups,
 Dr. Ernesto Chavez, Jr. } 06
 Reforma 510-102 } 10
 Mexico, D.F. Mexico

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.
 I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINER: Al R. Wichtrich } 03
 SIGNATURE: _____
 (PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall complete on all pages covered in block 20 thru 39))

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

2/RS