

Standard Form 99  
Rev. 1-1-63  
Prescribed by  
Department of the Army  
DA FORM 1-63

### 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: [Redacted]

2. GRADE AND COMMENT OR POSITION: [Redacted]

3. IDENTIFICATION NO.: [Redacted]

4. PURPOSE OF EXAMINATION: [Redacted]

5. DATE OF EXAMINATION: [Redacted]

6. RACE: **White**

7. DEPARTMENT, AGENCY, OR SERVICE: [Redacted]

8. ORGANIZATION UNIT: [Redacted]

9. DATE OF BIRTH: [Redacted]

10. PLACE OF BIRTH: **Mex**

11. NAME, RELATIONSHIP AND ADDRESS OF NEXT OF KIN: **Wife - Same as above.**

12. EXAMINING FACILITY OR EXAMINER'S ADDRESS: [Redacted]

13. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS: **Health normal - feel fine - no complaints.**

18. FAMILY HISTORY				19. HAS ANY BLOOD RELATION (Living, dead, or wife, or child, or grandchild, or wife)	
RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH	YES NO (Check each item)
FATHER			Pneumonia	86	X
MOTHER			"	76	X
SPOUSE	46	Normal			X
BROTHERS AND SISTERS	53	"			X
	52		Tuberculosis	52	X
	51	"			X
SISTERS	50	"			X
			Combar W.V II	33	X
CHILDREN	22	Excellent			X
	19	"			X
	14	"			X

20. HAVE YOU EVER HAD OR HAVE YOU NOW - Tick check at left of each item			
YES NO (Check each item)	YES NO (Check each item)	YES NO (Check each item)	YES NO (Check each item)
X SCARLET FEVER, ERYSIPELAS	X GOTTER	X TUMOR, GROWTH, CYST, CANCER	X TRICK OR LOCKED ANKLE
X DYPHTHERIA	X TUBERCULOSIS	X RUPTURE	X FOOT LOCK
X RHEUMATIC FEVER	X SCALDING BURNS (Specify on back)	X APPENDICITIS	X NEURALGIA
X SWOLLEN OR PAINFUL JOINTS	X ASTHMA	X HILLS OR PELVIC DISEASE	X PARALYSIS (Loc. Muscular)
X WARTS	X SHORTNESS OF BREATH	X FREQUENT OR PAINFUL URINATION	X EPILEPSY OR FITS
X WHOOPING COUGH	X PAIN OR PRESSURE IN CHEST	X KIDNEY STONE OR BLOOD IN URINE	X CAR. TRAIL, SEA, OR AIR SICKNESS
X FREQUENT OR SEVERE HEADACHE	X CHRONIC COUGH	X SUGAR OR ALBUMIN IN URINE	X FREQUENT TROUBLE SLEEPING
X DIZZINESS OR FAINTING SPELLS	X PALPITATION OR POUNDING HEART	X SORES	X FREQUENT OR TERRIFYING NIGHTMARES
X EYE TROUBLE	X HIGH OR LOW BLOOD PRESSURE	X GENERAL DISEASE	X DEPRESSION OR EXCESSIVE WORRY
X EAR, NOSE OR THROAT TROUBLE	X CRAMPS IN YOUR LEGS	X RECENT GAIN OR LOSS OF WEIGHT	X LOSS OF MEMORY OR APPETITE
X PAINING EARS	X FREQUENT INDIGESTION	X ARTHRITIS OR RHEUMATISM	X BED WETTING
X CHRONIC OR FREQUENT COLDS	X STOMACH ULCER OR INTESTINAL TROUBLE	X BONE JOINT, OR OTHER DEFORMITY	X NEURALGIC TROUBLE OF ANY SORT
X SEVERE TOOTH OR GUM TROUBLE	X GALL BLADDER TROUBLE OR GALL STONES	X CLAVENESS	X USE OF DRUG OR NARCOTIC HABIT
X SORE THROAT	X JAUNDICE	X LOSS OF ARM, LEG, FINGER, OR TOE	X EXCESSIVE DRINKING HABIT
X HAY FEVER	X ANY REACTION TO SERUM, DRUG OR MEDICINE	X HAND OR "WINK" SHOLLER OR ELBOW	X REMOVED ALL TENDENCIES

21. HAVE YOU EVER (Check each item)

22. FEMALES ONLY & HAVE YOU EVER - COMPLETE THE FOLLOWING

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS: **1**

24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS: **14**

25. WHAT IS YOUR USUAL OCCUPATION: **Business Management**

26. ARE YOU (Check each one)

4/RS