

Standard Form 90
Prescribed by
Bureau of the Budget
Circular 112

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		7. GRADE AND COMMENT OR POSITION	3. IDENTIFICATION NO.
[REDACTED]			
8. PURPOSE OF EXAMINATION		6. DATE OF EXAMINATION	
[REDACTED]		[REDACTED]	
9. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	10. RACE White	11. ORGANIZATION UNIT 6 1 1/2	
12. DATE OF BIRTH 6 1 1/2	13. PLACE OF BIRTH Mexico, D.C.	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Wife - Same as above. 66 Wc - 185 Ht - 6'3" (2/17/63)	
15. EXAMINING FACILITY OR EXAMINER'S ADDRESS [REDACTED]			

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS: *Follow by description of past history, if complaint exists.*
Health normal - feel fine - no complaints.

18. FAMILY HISTORY					19. HAS ANY BLIND RELATION (Far-sighted, near-sighted, etc.) (P. NO. 1840 OF WIFE)			
RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH	YES	NO	(Check each item)	RELATIONSHIP
FATHER			Pneumonia	86	X		HAD TUBERCULOSIS	Sister
MOTHER			"	76		X	HAD SYPHILIS	
SPOUSE	46	Normal			X		HAD DIABETES	Mother
SISTERS	53	"						
	52	"	Tuberculosis	52	X		HAD KIDNEY TROUBLE	
	51	"			X		HAD HEART TROUBLE	
CHILDREN	22	Excellent	Combat W.W. II	33	X		HAD STOMACH TROUBLE	
	19	"			X		HAD RHEUMATISM	
	14	"			X		HAD ASTHMA, HAY FEVER, HIVES	
	12	"			X		HAD EPILEPSY (Fit)	
	5	"			X		COMMITTED SUICIDE	
	3	"				X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW - *Put X 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)
<input checked="" type="checkbox"/>	SCARLET FEVER, ERYSIPELAS	<input checked="" type="checkbox"/>	GOUT	<input checked="" type="checkbox"/>	TUMOR, GROWTH, CYST, CANCER	<input checked="" type="checkbox"/>	"HOCK" OR LOCKED ANGLE
<input checked="" type="checkbox"/>	DIPHTHERIA	<input checked="" type="checkbox"/>	TUBERCULOSIS	<input checked="" type="checkbox"/>	RAVULP	<input checked="" type="checkbox"/>	FOOT TROUBLE
<input checked="" type="checkbox"/>	RHEUMATIC FEVER	<input checked="" type="checkbox"/>	SCALING SKIN	<input checked="" type="checkbox"/>	APPENDICITIS	<input checked="" type="checkbox"/>	NEURITIS
<input checked="" type="checkbox"/>	SWOLLEN OR PAINFUL JOINTS	<input checked="" type="checkbox"/>	ASTHMA	<input checked="" type="checkbox"/>	PULES OR PECTAL DISEASE	<input checked="" type="checkbox"/>	PARALYSIS (ERIC, HEMIPLEGIA)
<input checked="" type="checkbox"/>	MILKPS	<input checked="" type="checkbox"/>	SHORTNESS OF BREATH	<input checked="" type="checkbox"/>	FREQUENT OR PAINFUL URINATION	<input checked="" type="checkbox"/>	EPILEPSY OR FITS
<input checked="" type="checkbox"/>	WHOOPING COUGH	<input checked="" type="checkbox"/>	PAIN OR PRESSURE IN CHEST	<input checked="" type="checkbox"/>	KIDNEY STONE OR BLOCK IN URINE	<input checked="" type="checkbox"/>	CAR, TRAIN, SEA, OR AIR SICKNESS
<input checked="" type="checkbox"/>	FREQUENT OR SEVERE HEADACHE	<input checked="" type="checkbox"/>	CHRONIC COUGH	<input checked="" type="checkbox"/>	SUGAR OR ALBUMIN IN URINE	<input checked="" type="checkbox"/>	FREQUENT TROUBLE SLEEPING
<input checked="" type="checkbox"/>	DOZINESS OR FAINTING SPELLS	<input checked="" type="checkbox"/>	PALPITATION OR POUNDING HEART	<input checked="" type="checkbox"/>	BOILS	<input checked="" type="checkbox"/>	FREQUENT OR TERRIFYING NIGHTMARES
<input checked="" type="checkbox"/>	EYE TROUBLE	<input checked="" type="checkbox"/>	HIGH OR LOW BLOOD PRESSURE	<input checked="" type="checkbox"/>	MENTAL DISEASE	<input checked="" type="checkbox"/>	DEPRESSION OR EXCESSIVE WORRY
<input checked="" type="checkbox"/>	EAR, NOSE OR THROAT TROUBLE	<input checked="" type="checkbox"/>	CRAMPS IN YOUR LEGS	<input checked="" type="checkbox"/>	RECENT GAIN OR LOSS OF WEIGHT	<input checked="" type="checkbox"/>	LOSS OF MEMORY OR APATHY
<input checked="" type="checkbox"/>	PLUNGING EARS	<input checked="" type="checkbox"/>	FREQUENT INDIGESTION	<input checked="" type="checkbox"/>	ARTHRITIS OR RHEUMATISM	<input checked="" type="checkbox"/>	BED WETTING
<input checked="" type="checkbox"/>	CHRONIC OR FREQUENT COLDS	<input checked="" type="checkbox"/>	STOMACH ULCER OR INTESTINAL TROUBLE	<input checked="" type="checkbox"/>	BONE JOINT, OR OTHER DEFORMITY	<input checked="" type="checkbox"/>	NEURALGIC TROUBLE OF ANY SORT
<input checked="" type="checkbox"/>	SEVERE TOOTH OR GUM TROUBLE	<input checked="" type="checkbox"/>	GALL BLADDER TROUBLE OR GALL STONES	<input checked="" type="checkbox"/>	LAMENESS	<input checked="" type="checkbox"/>	ADDICTION TO DRUGS OR NARCOTIC HABIT
<input checked="" type="checkbox"/>	SINUSITIS	<input checked="" type="checkbox"/>	JAW-ACH	<input checked="" type="checkbox"/>	LOSS OF ARM, LEG, FINGER, OR TOE	<input checked="" type="checkbox"/>	EXCESSIVE DRINKING HABIT
<input checked="" type="checkbox"/>	HAY FEVER	<input checked="" type="checkbox"/>	ANY REACTION TO SERUM, DRUG OR MEDICINE	<input checked="" type="checkbox"/>	WOUND OR "ROCK" SHOULDER OR ELBOW	<input checked="" type="checkbox"/>	ALCOHOLIC TENDENCIES

21. HAVE YOU EVER (Check each item)		22. FEMALES ONLY A. HAVE YOU EVER—		B. COMPLETE THE FOLLOWING	
<input checked="" type="checkbox"/>	WORN GLASSES	<input checked="" type="checkbox"/>	ATTEMPTED SUICIDE	BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION
<input checked="" type="checkbox"/>	WORN AN ARTIFICIAL EYE	<input checked="" type="checkbox"/>	BEEN A SLEEP WALKER	HAD A vaginal DISCHARGE	INTERVAL BETWEEN PERIODS
<input checked="" type="checkbox"/>	WORN HEARING AIDS	<input checked="" type="checkbox"/>	USED BY ANY ONE WHO HAD TUBERCULOSIS	BEEN TREATED FOR A PEMALE DISORDER	DURATION OF PERIODS
<input checked="" type="checkbox"/>	STUTTERED OR STAMMERED	<input checked="" type="checkbox"/>	COUGHED UP BLOOD	HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD
<input checked="" type="checkbox"/>	WORN A BRACE OR BACK SUPPORT	<input checked="" type="checkbox"/>	WAS EVER INJURED BY ANOTHER PERSON	HAD PAINFUL MENSTRUATION	QUANTITY <input type="checkbox"/> Normal <input type="checkbox"/> Excessive <input type="checkbox"/> Scarce
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?		26. ARE YOU (C) (a) (b) (c)	
		Business Management		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single	

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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
	<input checked="" type="checkbox"/>	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF A. SENSITIVITY TO CHEMICALS, DUST, SMOKE, ETC.
	<input checked="" type="checkbox"/>	B. INABILITY TO PERFORM CERTAIN WORKS
	<input checked="" type="checkbox"/>	C. INABILITY TO ASSUME CERTAIN POSITIONS
	<input checked="" type="checkbox"/>	D. OTHER MEDICAL REASONS (If yes, give reasons)
	<input checked="" type="checkbox"/>	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	<input checked="" type="checkbox"/>	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (If yes, give details)
	<input checked="" type="checkbox"/>	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (If yes, state reason and give details)
	<input checked="" type="checkbox"/>	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (If yes, state reason and give details)
	<input checked="" type="checkbox"/>	32. HAVE YOU HAD OR WERE YOU EVER ADVISED TO HAVE ANY OPERATIONS? (If yes, describe and give age at which occurred)
	<input checked="" type="checkbox"/>	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)
	<input checked="" type="checkbox"/>	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (If yes, specify when, where, and give details)
	<input checked="" type="checkbox"/>	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.)
	<input checked="" type="checkbox"/>	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (If yes, which illnesses)
	<input checked="" type="checkbox"/>	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (If yes, give date and reasons for rejection)
	<input checked="" type="checkbox"/>	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)
	<input checked="" type="checkbox"/>	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 25 thru 39)

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