



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 by lines 20 thru 39)

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

2/RS