104-10175-10180

Standard Form 49
Prescribed by
Bureau of the Budget
Circular No. A-64

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 | 2. GRADE AND COMPONENT OR POSITION | 3. IDENTIFICATION NO.

[redacted] | 5. PURPOSE OF EXAMINATION | 6. DATE OF EXAMINATION

7. [redacted] Mexico, D. F. | 8. ARMED SERVICE | 9. DEPARTMENT, AGENCY, OR SERVICE | 10. ORGANIZATION UNIT

M | White | Military | 6 | Civilian | 11/2

12. DATE OF BIRTH | 13. PLACE OF BIRTH | 14. NAME, RELATIONSHIP AND ADDRESS OF NEXT OF KIN

[redacted] Mex [redacted] - Wife - Same as above.

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS | 16. PHYSICAL DESCRIPTION

W: - 185
Ht - 6'3" (2/17/53)

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. (Follow by description of past illness, if complete enough)

Health normal - feel fine - no complaints.

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD CAUSE OF DEATH	AGE AT DEATH
FATHER			Pneumonia	86
MOTHER			"	76
SPOUSE	46	Normal		
	53	"		
BROTHERS AND SISTERS	52		Tuberculosis	52
	51	"		
	50	"		
			Combat W.W II	33
CHILDREN	22	Excellent		
	19	"		
	14	"		
	12	"		
	8	"		

19. HAS ANY BLOOD RELATION (Parents, brother, sister, other than listed) OR WIFE

YES	NO	(Check each item)	RELATION
X		HAD TUBERCULOSIS	Sister
	X	HAD SYPHILIS	
X		HAD DIABETES	Mother
		HAD CANCER	
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY (Fits)	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW - (Place 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	GOITER		X	TRICK OR LOCKED KNEE
	X	DIPHTHERIA		X	T. B. EXPOSURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	T. B. CONTACT (Spit in eyes)		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PARALYSIS (Any, full or partial)
X		MUMPS		X	SHORTNESS OF BREATH		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	CAR, TRAIN, SEA, OR AIR SICKNESS
X		FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	FREQUENT TROUBLE SLEEPING
	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE	X		HIGH OR LOW BLOOD PRESSURE		X	DEPRESSION OR EXCESSIVE WORRY
X		EAR, NOSE OR THROAT TROUBLE		X	CRAMPS IN YOUR LEGS		X	LOSS OF MEMORY OR AMNESIA
	X	RUNNING EARS		X	FREQUENT INDIGESTION		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	HABIT DRUG OR NARCOTIC HABIT
X		SINUSITIS		X	JAUNDICE		X	EXCESSIVE DRINKING HABIT
	X	HAY FEVER	X		ANY REACTION TO SERUM, DRUG OR MEDICINE		X	HOMICIDAL TENDENCIES

21. HAVE YOU EVER (Check each item)

X	WORN GLASSES		ATTEMPTED SUICIDE	
	WORN AN ARTIFICIAL EYE		BEEN A SLEEP WALKER	
	WORN HEARING AIDS		LIVED WITH ANYONE WHO HAD TUBERCULOSIS	
	STUTTERED OR STAMMERED		COUGHED UP BLOOD	
	WORN A BRACE OR BACK SUPPORT		BEEN REJECTED AFTER ENLISTMENT OR INDUCTION FOR MILITARY SERVICE	

22. FEMALES ONLY. HAVE YOU EVER— | B. COMPLETE THE FOLLOWING

BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION
HAD A VAGINAL DISCHARGE	INTERVAL BETWEEN PERIODS
BEEN TREATED FOR A FEMALE DISORDER	DURATION OF PERIODS
HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD
HAD IRREGULAR MENSTRUATION	QUANTITY ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

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 one): ☒ RIGHT HANDED ☐ LEFT HANDED

4/Rs