104-10175-10182

Standard Form 88
(Rev. Aug 1954)
Promulgated by
Bureau of the Budget
Circular A-34

REPORT OF MEDICAL HISTORY

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

	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
	PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION

7. SEX: M | 8. RACE: WHITE | 9. TYPE OF ACTIVE GOVT SERVICE: MILITARY 6 / CIVILIAN 12 | 10. DEPARTMENT, AGENCY OR SERVICE | 11. ORGANIZATION UNIT

12. DATE OF BIRTH: 09,1 | 13. PLACE OF BIRTH: [redacted] IOWA | 14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN: WIFE - SAME AS ABOVE

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS: / | 06 | 16. OTHER INFORMATION: WT - 125 - 5' 3" - 2-17-43

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

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER	—	—	PNEUMONIA	66
MOTHER	—	—	"	76
SPOUSE	46	NORMAL		
BROTHERS AND SISTERS	53	"		
	52	—	TUBERCULOSIS	55
	51	"		
	50	"		
	45	—	COMBAT WWII	33
CHILDREN	22	EXCELLENT		
	19	" "		
	14	" "		
	12	" "		
	8	" "		

19. HAS ANY BLOOD RELATION (Parent, brother, sister, other) EVER HAD:

YES	NO	(Check each item)	RELATION(S)
	✓	TUBERCULOSIS	SISTER
	✓	SYPHILIS	
✓		DIABETES	MOTHER
	✓	CANCER	
	✓	KIDNEY TROUBLE	
	✓	HEART TROUBLE	
	✓	STOMACH TROUBLE	
	✓	RHEUMATISM (Arthritis)	
	✓	ASTHMA, HAY FEVER, HIVES	
	✓	EPILEPSY (Fits)	
	✓	COMMITTED SUICIDE	
	✓	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)	YES	NO	(Check each item)
	✓	SCARLET FEVER, ERYSIPELAS		✓	GOITER		✓	TUMOR, GROWTH, CYST, CANCER		✓	"TRICK" OR LOCKED KNEE
	✓	DIPHTHERIA		✓	TUBERCULOSIS		✓	RUPTURE		✓	FOOT TROUBLE
	✓	RHEUMATIC FEVER		✓	SOAKING SWEATS (Night sweats)		✓	APPENDICITIS		✓	NEURITIS
	✓	SWOLLEN OR PAINFUL JOINTS		✓	ASTHMA		✓	PILES OR RECTAL DISEASE		✓	PARALYSIS (Inc. infantile)
✓		MUMPS		✓	SHORTNESS OF BREATH		✓	FREQUENT OR PAINFUL URINATION		✓	EPILEPSY OR FITS
	✓	WHOOPING COUGH		✓	PAIN OR PRESSURE IN CHEST		✓	KIDNEY STONE OR BLOOD IN URINE		✓	CAR, TRAIN, SEA, OR AIR SICKNESS
✓		FREQUENT OR SEVERE HEADACHE		✓	CHRONIC COUGH		✓	SUGAR OR ALBUMIN IN URINE		✓	FREQUENT TROUBLE SLEEPING
	✓	DIZZINESS OR FAINTING SPELLS		✓	PALPITATION OR POUNDING HEART		✓	BOILS		✓	FREQUENT OR TERRIFYING NIGHTMARES
	✓	EYE TROUBLE		✓	HIGH OR LOW BLOOD PRESSURE		✓	VENEREAL DISEASE		✓	DEPRESSION OR EXCESSIVE WORRY
✓		EAR, NOSE OR THROAT TROUBLE		✓	CRAMPS IN YOUR LEGS		✓	RECENT GAIN OR LOSS OF WEIGHT		✓	LOSS OF MEMORY OR AMNESIA
	✓	RUNNING EARS		✓	FREQUENT INDIGESTION		✓	ARTHRITIS OR RHEUMATISM		✓	BED WETTING
	✓	CHRONIC OR FREQUENT COLDS		✓	STOMACH, LIVER OR INTESTINAL TROUBLE		✓	BONE, JOINT, OR OTHER DEFORMITY		✓	NERVOUS TROUBLE OF ANY SORT
	✓	SEVERE TOOTH OR GUM TROUBLE		✓	GALL BLADDER TROUBLE OR GALL STONES		✓	LAMENESS		✓	ANY DRUG OR NARCOTIC HABIT
	✓	SINUSITIS		✓	JAUNDICE		✓	LOSS OF ARM, LEG, FINGER, OR TOE		✓	EXCESSIVE DRINKING HABIT
	✓	HAY FEVER		✓	ANY REACTION TO SERUM, DRUG OR MEDICINE		✓	PAINFUL OR "TRICK" SHOULDER OR ELBOW		✓	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (Check each item)

✓	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	✓	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

22. FEMALES ONLY A. 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? 3-5-6-93 Riveter

26. ARE YOU (Check one) ☑ RIGHT HANDED ☐ LEFT HANDED

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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	
	✓	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS DUST SUNLIGHT ETC.	
	✓	B. INABILITY TO PERFORM CERTAIN MOTIONS	
	✓	C. INABILITY TO ASSUME CERTAIN POSITIONS	
	✓	D. OTHER MEDICAL REASONS (*If yes, give reasons*)	
	✓	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCES?	
	✓	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)	
	✓	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)	
	✓	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)	
	✓	32. HAVE YOU HAD OR HAVE YOU BEEN ADVISED TO HAVE ANY OPERATIONS? (*If yes, describe and give age at which occurred*)	
	✓	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital*)	
	✓	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)	
✓		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*)	ROUTINE ANESTHETICS 61 08
	✓	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)	
	✓	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)	
	✓	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*)	
	✓	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*)	

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.

	03		03
	DATA (*Physician shall complete*)		

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

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