

Medical Pre-Screening Form

Name: _____ School: _____ Class: _____
Date: _____ SSN #: _____ Phone#: _____

Please be as complete as possible when answering these questions. A "yes" answer does not mean you are disqualified from ROTC, the information will assist us process your DoDMERB medical examination.

1. List any medications you are taking, even if only intermittently:
2. Have you ever been evaluated or treated for a psychological disorder such as depression, bipolar disorder, suicidal behavior, self mutilation, obsessive/compulsive disorder, anorexia, bulimia, attention deficit (ADD), Hyperactive Disorder (ADHD)? Do you have a learning disorder, are you eligible for or do you receive academic accommodations such as extra time on examinations?
 Yes No
3. Have you ever taken medication for a psychological disorder? Yes No
4. Have you had any musculoskeletal injuries including knee injuries/pain, fractures, dislocations, back pain or shin splints etc? If yes please list the injuries Yes No
If yes list injuries _____
5. Do you have any skin condition such as psoriasis, eczema, etc.? Yes No
6. Have you ever had surgery including outpatient surgeries? Yes No
If yes list procedure _____
7. Have you had asthma, brochospasm or reactive airway disease after age 13? Yes No
If yes, when was the last time you took medication for asthma _____
8. Have you ever been diagnosed with the following?

a. Diabetes	<input type="radio"/> Yes <input type="radio"/> No	h. Head Injury	<input type="radio"/> Yes <input type="radio"/> No
b. Ulcers/Ulcerative Colitis	<input type="radio"/> Yes <input type="radio"/> No	i. Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
c. Crohn's Disease	<input type="radio"/> Yes <input type="radio"/> No	j. Cancer	<input type="radio"/> Yes <input type="radio"/> No
d. High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	k. Heart Disease	<input type="radio"/> Yes <input type="radio"/> No
e. Scoliosis (curvature of the spine)	<input type="radio"/> Yes <input type="radio"/> No	l. Migraine headaches	<input type="radio"/> Yes <input type="radio"/> No
f. Seizures (epilepsy)	<input type="radio"/> Yes <input type="radio"/> No	m. Endometriosis	<input type="radio"/> Yes <input type="radio"/> No
g. Tourette's Syndrome	<input type="radio"/> Yes <input type="radio"/> No	n. Sleepwalking	<input type="radio"/> Yes <input type="radio"/> No
9. Have you ever had a severe reaction to a bee/wasp/yellow jacket sting or fire ant bite? Yes No
10. Are you receiving allergy shots? Yes No
11. Do you have any eye disorders including sever near sightedness, astigmatism, or double vision? Yes No
12. If prior service did you have a permanent profile, were you ever separated or denied entry into the military for medical or psychological reasons? Yes No
13. Are you receiving disability payments from any Federal, State or Local Agency? Yes No
14. Do you wear glasses? Yes No Do you wear contact lenses? Yes No
15. Do you have any other medical condition or concerns that are not mentioned above? Yes No

By signing this form, I acknowledge that I have disclosed any and all pre-existing medical conditions that would make me ineligible for enrollment in the ROTC program as specified in statute, and Army regulations (AR 145-1). Failure disclose or to have disclosed any disqualifying conditions, including any conditions I should have known about, will subject me to disenrollment from the ROTC program.

Signature: _____

Cadre Review: _____

Printed Name: _____

Medical Review (for all "yes" answers): _____

Date: _____

Please explain any Yes answers above or on the back of this paper.