



# Marine Military Academy

ADMISSIONS OFFICE

320 Iwo Jima Boulevard

Harlingen, TX 78550

TEL: (956) 423-6006 FAX: (956) 421-9273

## REPORT OF MEDICAL HISTORY

(Submit to Physician or Medical Provider)

Name of Cadet (Applicant): \_\_\_\_\_  
(please print) Last First Middle

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address of Next of Kin \_\_\_\_\_

Parent/Guardian Phone(s) \_\_\_\_\_  
Home Business

### Immunization History: (Texas State requires the accurate report of Immunization Dates - Fill in with MM/DD/YY)

DPT/DT (3 +1 after age 4 and within ten years)						
Polio (3 +1 after age 4)						
Measles/Mumps/Rubella (2 if born after 01/1/78)						
Hep B						
Varicella Vaccine						

Report of Physical: Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Blood Type: \_\_\_\_\_

\*Visual Acuity: OD \_\_\_\_\_ OS \_\_\_\_\_ OU \_\_\_\_\_ \*Hearing: AD \_\_\_\_\_ AS \_\_\_\_\_ WNL \_\_\_\_\_ AU \_\_\_\_\_

\*Mandatory State Requirement

### Please answer all of the following questions: (comment on all positive answers; use a separate sheet if needed)

	YES	NO		YES	NO		YES	NO
Chicken Pox; If yes, state age:	0	0	Chronic Cough	0	0	Anxiety/Nervousness	0	0
Measles	0	0	Sinusitis/Hay fever	0	0	Panic disorder	0	0
German Measles	0	0	Asthma	0	0	Bipolar I, II, nos	0	0
Mumps	0	0	Tuberculosis	0	0	Depression/Dysthymia	0	0
ENT Problems	0	0	Kidney Disease	0	0	ODD	0	0
Pulmonary Problems	0	0	Cardiac Disease	0	0	OCD	0	0
Neurological Problems	0	0	Orthopedic Problems	0	0	PTSD	0	0
Congenital Abnormalities	0	0	Surgery/Operations	0	0	Tourettes Syndrome	0	0
Alcohol or Drug Use	0	0	Head Injury	0	0	ADD/ADHD	0	0
Nocturnal Enuresis	0	0	Seizures/Epilepsy	0	0	Insomnia	0	0
Schizophrenia	0	0	Conduct disorder	0	0	Asperger Syndrome	0	0
Paranoia/Psychosis	0	0	IED	0	0	Autism	0	0

Other Unlisted Problems/Conditions (Explain: attach office notes or use separate sheet)

### Are the following systems normal? (Please fully describe any abnormalities.)

	NORMAL	ABNORM		YES	NO
1. Head/Ears/Eyes/Nose/Throat	0	0	<b>ALLERGIES:</b>		
2. Respiratory System	0	0	10. Penicillin	0	0
3. Cardiovascular System	0	0	11. Sulfa Drugs	0	0
4. Gastrointestinal	0	0	12. Serum	0	0
5. Genitourinary/Hernia	0	0	13. Foods (state which) _____	0	0
6. Musculoskeletal	0	0	14. Other: _____		
7. Metabolic/Endocrine	0	0			
8. Neuropsychiatric	0	0			
9. Dermatological/skin disorder	0	0			

Is there impaired function of any organ? (Please list) \_\_\_\_\_ YES 0 NO 0

Does the applicant have any physical limitations? (Please list) \_\_\_\_\_ YES 0 NO 0

Is the applicant undergoing or has undergone psychiatric treatment? (Please list) \_\_\_\_\_ YES 0 NO 0

Is the applicant undergoing or has undergone medical treatment? (Please list) \_\_\_\_\_ YES 0 NO 0

Is the applicant taking medication? (Please list) \_\_\_\_\_ YES 0  
NO 0

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

(please print or stamp)

Address: \_\_\_\_\_