PUERTO RICO STATE GUARD REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons)

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information.

PLEASE RETURN COMPLETED YOUR FORM TO YOUR PUERTO RICO STATE GUARD RECRUITER, SURGEON, OR DESIGNEE ONLY.

PRIVACY ACT STATEMENT

AUTHORITY: The Health Insurance Portability and Accountability Act, HIPAA 104-191, Aug. 21, 1996. Military Code of Puerto Rico, Law Number 88 of August 8, 2023.

PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Puerto Rico State Guard Command. The information collected on this form is used to assist Puerto Rico State Guard physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. A notice of privacy practices can be viewed at: https://www.salud.gov.pr/CMS/166.

ROUTINE USE(S): The Blanket Routine: Uses apply to this collection. This form PRSG 2807-1 is also available at http://prsg.us

DISCLOSURE: Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Puerto Rico State Guard. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For a Puerto Rico State Guard member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Provide false information is penalized by federal and Commonwealth of Puerto Rico laws.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	**2. LAST FOUR SOCIAL SECURITY**	**3. TODAY'S DATE** (*DD/MM/YYYY*)

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*	**5.a. EXAMINING LOCATION & ADDRESS**	**5.b. GENDER**
	CAMP SANTIAGO, SALINAS, PUERTO RICO	☐ MALE ☐ FEMALE
5.c. TELEPHONE NUMBER *(Include Area Code)*	**5.d. AGE:**	**5.e. HEIGHT:**
	5.f. WEIGHT:	**5.g. BMI:**

X ALL APPLICABLE BOXES:

6.a. SERVICE (MSC)	**6.b. MILITARY STATUS**	**6.c. PURPOSE OF EXAMINATION**		**7.a. POSITION**
☐ Army	☐ New Member	☐ MEPS	☐ SRP	Grade Rank
☐ Air Group	☐ Active	☐ PHA	☐ AT	
☐ Medical Command		☐ Med.Board	☐ Ret.Board	**7.b. CIVILIAN OCUPATION**
			☐ Other *(specify)* _____	

8. CURRENT MEDICATIONS *(Prescription and Over the Counter)*	**9. ALLERGIES** *(Including insect bites/stings, foods, medicine, or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	**YES**	**NO**
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worm contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a Painful shoulder, elbow, or wrist *(e.g., pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. CONTINUED	**YES**	**NO**
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
j. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
k. Any need to use corrective devices such as prosthetic devices, Knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin d *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	LAST FOUR SOCIAL SECURITY

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attack)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(DD-MM-YYYY)*		
e. Date of last PAP smear *(DD-MM-YYYY)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and more of doctor and complete address of hospital?*	○	○
22. Have you ever had, or have you been advised to have any operation or surgery? *(If yes, describe and give age at which occurred)*	○	○
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	LAST FOUR SOCIAL SECURITY

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important and record any significant findings here.)*

COMMENTS

30. IMMUNIZATION HISTORY *(Pease answer the following questions about your immunization history)*

		YES	NO
a.	Have you received an Influenza Vaccination (Flu Shot) this year (Are you current)?	○	○
b.	To your knowledge, have you received a Tetanus shot or vaccination called a DTap, Tdap, or DTP in the las ten (10) years?	○	○
c.	Have you had a Hepatitis B series of 2, 3 or 4 shots or have a positive Hepatitis B surface antybody?	○	○
d.	Have you been diagnosed with having an immune deficiency disorder, a weakened immune system, have a family Member with an immune deficiency or are being treated for cancer or receiving chemotherapy?	○	○
e.	Have you received a COVID-19 Vaccination?	○	○

☐ 1 Dosis	☐ 2 Dosis	☐ 3 Dosis	☐ Additional Dosis _____

31.a. TYPED OR PRINTED NAME OF PRSG Member *(Last, First, Middle Initial)*	b. SIGNATURE OF MEMBER *(SOILDER)*	c. DATE SIGNED ***(DD-MM-YYYY)***

d. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	e. SIGNATURE OF EXAMINER *(PHYSICIAN)*	f. DATE SIGNED ***(DD-MM-YYYY)***