

MEDICAL RECORD--SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General.

REPORT TITLE SUPPLEMENTAL MEDICAL HISTORY (CONTINUATION OF DD FORM 2807-1) AND INITIAL OCCUPATIONAL HISTORY FOR CHEMICAL AGENT WORKERS	OTSG APPROVED (Date) (YYYYMMDD)
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INSTRUCTIONS: Answer questions 1-54 by checking the appropriate box. Explain all "Yes" answers in block 56 on page 3 of this form.

	Yes	No	Unsure
1. Have you ever taken corticosteroids (for example, Prednisone or Prednisolone) for long periods of time?			
2. Have you had your spleen removed?			
3. Have you ever had chemotherapy or radiation therapy (such as for the treatment of cancer)?			
4. Have you ever had a condition that affects your immune system?			
5. Do you have a history of eczema, psoriasis, open sores, burns or any skin disorder?			
6. Have you ever been hospitalized for illness or injury?			
7. Have you ever had surgery?			
8. Have you ever undergone hypnosis (for example, for smoking cessation or weight control)?			
9. Are you or your spouse pregnant or planning pregnancy?			
10. Have you developed an illness you think was job-related?			
11. Have you changed jobs or work environments due to illness or injury?			
12. Have you ever worked with a substance that made your nose, chest or sinuses congested?			
13. Have you ever worked with a substance that irritated your skin or caused a skin rash?			
14. Have you ever worked with a substance that caused numbness, tingling or weakness.			
15. Do you have a second job?			
16. Have you experienced a change in your hearing due to work in a noisy environment (posted "noise hazardous").			
17. Have you ever experienced health problems related to exposure to vibration from your workplace (tools, vehicles)?			
18. Have you ever had difficulty wearing or using a respirator in your work?			
19. Have you ever worked with asbestos? (If yes, consider completing and submitting DD Form 2493-1 or 2493-2.)			
20. Have you ever worked in a setting, such as a hospital or an ambulance, where you might have been exposed to biohazardous materials, such as blood, urine or other body fluids?			
21. Have you ever experienced pain from work that required repeated motions of a part of your body, such as your wrist, knees or back?			
22. Have you suffered health effects from working in dusty environments?			
23. Have you had skin sensitivity or allergies from wearing latex gloves? (If "Yes," complete the Latex Questionnaire.)			
24. Have you experienced difficulty wearing encapsulating ensembles in your work, such as Level A or Level B?			
25. Have you ever had a job-related injury?			
26. Do you have a disability rating, such as from Veterans Affairs or a State?			
27. Have you ever received disability payments?			
28. Do you have any hobbies? If so, list them here:			
29. Have you ever had work-related exposures to cholinesterase-inhibiting substances?			
30. Have you ever been told that you were exposed to substances associated with cardiovascular (heart) disease?			
31. Have you ever been told that you were exposed to substances associated with pulmonary (lung) disease?			

(Continue on reverse)

PREPARED BY <i>(Signature & Title)</i>	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)
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PATIENT'S IDENTIFICATION <i>(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)</i>	<table style="width:100%;"> <tr> <td><input type="checkbox"/> HISTORY/PHYSICAL</td> <td><input type="checkbox"/> FLOW CHART</td> </tr> <tr> <td><input type="checkbox"/> OTHER EXAMINATION OR EVALUATION</td> <td><input type="checkbox"/> OTHER <i>(Specify)</i></td> </tr> <tr> <td><input type="checkbox"/> DIAGNOSTIC STUDIES</td> <td></td> </tr> <tr> <td><input type="checkbox"/> TREATMENT</td> <td></td> </tr> </table>	<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> FLOW CHART	<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER <i>(Specify)</i>	<input type="checkbox"/> DIAGNOSTIC STUDIES		<input type="checkbox"/> TREATMENT	
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