

**FEDERAL BUREAU OF INVESTIGATION
REPORT OF MEDICAL HISTORY**

Privacy Act Statement: The collection of this information on this form, which is authorized by 5 U.S.C. § 301 and 5 U.S.C. § 3301, is relevant and necessary to provide appropriate medical care and to determine eligibility and/or fitness for duty. Completion of this form is voluntary; however, your failure to supply all the information requested on this form may impede or preclude agency action regarding medical care or continued employment.

GINA Notice: Do Not Provide Genetic Information, Including Family Medical History

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. See 29 C.F.R. § 1635.8(b)(1)(i)(B).

This information is maintained in your medical file in the FBI Central records System, Justice/FBI-002, a description of which can be found at <http://home.fbinet.fbi/DO/OGC/LTB/PCLU/PrivacyCivil%20Liberties%20Library/Forms/FBI002.aspx>. This information may be disclosed in accordance with the routine uses referenced in this notice.

Date of Exam _____

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. Name of Patient (Last, first, middle)		2. Identification/67#	3. Grade
4. Division/Field Office Address		4a. Examining Facility	
4b. City	4c. State	4d. Zip Code	
5. Purpose of Examination			
5a. Height	5b. Weight	6. Are you (Check One) <input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed	

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

8. Present Health	8a. Current Medication	8b. Regular or Interm.
8c. Occupation		
9. Allergies (Include insect bites/stings and common foods)		

10. PAST/CURRENT MEDICAL HISTORY

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household contact with anyone with tuberculosis				Eye surgery to correct vision				Swollen or painful joints			
Tuberculosis or positive TB test				Lack vision in either eye				Frequent or severe headaches			
Blood in sputum or when coughing				Wear a hearing aid				Dizziness or fainting spells			
Excessive bleeding after injury or dental work				Wear a brace or back support				Eye trouble			

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Suicide attempt or plans				Stutter or stammer				Hearing loss			
Sleepwalking				Scarlet fever				Recurrent ear infections			
Wear corrective lenses				Inability to assume certain positions				"Trick" or locked knee			
Severe tooth or gum trouble				Rheumatic fever				Chronic or frequent colds			
Sinusitis				Tumor, growth cyst, cancer				Foot trouble			
Hay fever or allergic rhinitis				Hernia				Nerve Injury			
Head injury				Hemorrhoids or rectal disease				Paralysis (including infantile)			
Asthma				Frequent or painful urination				Epilepsy or seizure			
Shortness of breath				Bed wetting since age 12				Car, train, sea or air sickness			
Pain or pressure in chest				Kidney stone or blood in urine				Frequent trouble sleeping			
Chronic cough				Sugar or albumin in urine				Depression or excessive worry			
Palpitation or pounding heart				Sexually transmitted diseases				Loss of memory or amnesia			
Heart trouble				Recent gain or loss of weight				Nervous trouble of any sort			
High or low blood pressure				Eating disorder (anorexia bulimia, etc.)				Periods of unconsciousness			
Cramps in your legs				Arthritis, Rheumatism, or Bursitis				X-ray or other radiation therapy			
Frequent indigestion				Thyroid trouble or goiter				Chemotherapy			
Stomach, liver or intestinal trouble				Sensitivity to chemicals, dust, sunlight				Asbestos or toxic chemical exposure			
Gall bladder trouble or gallstones				Inability to perform certain motions				Plate, pins or rod in any bone			
Jaundice or hepatitis				Bone, joint or other deformity				Easy fatigability			
Broken bones				Loss of finger or toe				Been told to cut down or criticized for alcohol use			
Adverse reaction to medication				Painful or "trick" shoulder or elbow				Diabetes			
Skin diseases				Recurrent back pain or any back injury				Used tobacco			

11. FEMALE ONLY

Check Each Item	Yes	No	Don't Know	Date of Last Menstrual Period	Date of Last Pap Smear	Date of Last Mammogram
Treated for a female disorder						
Change in menstrual pattern						

Check Each Item, If "Yes" Explain in Blank Space To Right. List explanation By Item Number.

Item	Yes	No
12. Have you been treated for a mental condition? If yes, specify when, where, and give details.)		
13. Have you been denied life insurance? If yes, state reason and give details.)		
14. Have you had, or have been advised to have, any operation? (If yes, describe.)		
15. Have you been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		
16. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the year, for other than minor illnesses?		
17. Do you have a past or current medical history of any other condition not mentioned on this form?		
18. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		
19. Immunization		

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 purpose of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

20. Typed or Printed Name of Examinee	20a. Signature	20b. Date
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NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY"

21. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Item 7 through 11. Physicians may develop by interview any additional medical history deemed important, and record any significant findings here.

22. Typed or Printed Name of Physician or Examiner	22a. Signature	22b. Date
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