# HISTORY OF HEALTH FORM

**This page must be completed by the applicant.** Please check each item below regarding your medical history. You must comment on any "yes" response in the space provided or by attaching an additional sheet.

1. _____
Applicant's Last Name First Name Middle Name

2. Date of Birth_____ 3. E-mail Address _____

4. Home Phone _____ 5. Cell Phone_____

6. _____
Street address

_____ _____ _____
City State Zip Code

7. Have you had or do you have now any of the following conditions? **ALL QUESTIONS MUST BE ANSWERED**

| Yes | No | (Check each item) | Yes | No | (Check each item) | Yes | No | (Check each item) |
|---|---|---|---|---|---|---|---|---|
| | | Asthma or Wheezing | | | Loss of arm, leg, finger or toe | | | Chest pain or palpitations |
| | | Chronic cough or lung disease | | | Back pain or back brace | | | Epilepsy or fits |
| | | Shortness of breath | | | Stomach, liver or gallbladder trouble | | | Alcohol/Drug Problem |
| | | Frequent or severe headaches/migraines | | | | | | Take medications regularly |
| | | Eye trouble (other than vision correction) | | | Intestinal problem | | | Loss of Consciousness/Concussion |
| | | Wear glasses or contacts | | | Eating Disorder | | | Fainting or dizziness |
| | | Ear, nose or throat problems | | | Attempted Suicide | | | Diabetes |
| | | Tooth or jaw problems | | | Anxiety | | | Bleeding problems |
| | | Swollen or painful joints | | | Depression | | | Kidney problem or blood in urine |
| | | Muscle weakness or paralysis | | | ADHD | | | Tattoo (if yes describe and give size/ location) |
| | | Have you ever engaged in counseling for a psychological condition? | | | Tumor or cancer | | | |
| | | | | | Bone or joint injury | | | Hearing problems/hearing aids |
| | | Have you ever been hospitalized for a mental health reason? | | | Arthritis | | | Surgery |
| | | | | | Speech disorder | | | **Females only:** |
| | | Have you ever been treated with medication for a psychological condition? | | | Allergy to medicine, food, stings | | | Menstrual irregularity |
| | | | | | Heart problem | | | Gynecological problems |

8. Remarks **(REQUIRED)** – All "yes" answers in Section #7 above must be explained in this section. For all injuries include dates and indicate if you are fully recovered. Use additional sheet if necessary.

_____
_____
_____
_____
_____
_____

**I understand that failure to report previous physical or mental health conditions will be grounds for termination of my cadetship with forfeiture of appropriate tuition and fees. Additionally, if I have a recurrence of a pre-cadetship disorder, and am not able to participate fully in all aspects of cadet life, I understand that my cadetship could be terminated. I further understand that all medical documentation submitted during the appointment process may be shared with appropriate Institute officials in the case of a medical condition that may disqualify me from further participation as a VMI cadet, or if it is discovered that false, misleading, or inaccurate information has been provided.**

**Student signature (REQUIRED)** _____ Date _____