APPENDIX B: NYG Form 6130.2 Report of Medical History

MEDICAL RECORD | **NEW YORK GUARD REPORT OF MEDICAL HISTORY** | 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 NUMBER | 3. GRADE

4a. HOME ADDRESS (Street or RFD; City or Town; State and ZIP code) | 5. EXAMINING FACILITY

4b. CITY | 4c. STATE | 4d. ZIP CODE

6. PURPOSE OF EXAMINATION ☐ ENLISTMENT/REINLISTMENT ☐ PERIODIC ☐ OTHER

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Continue on back if needed)

7a. PRESENT HEALTH | 7b. CURRENT MEDICATIONS - STANDARD OR INTERIM

7c. ALLERGIES (Include insect bites/stings and common foods) | 7d. HEIGHT | 7e. WEIGHT

8. PATIENT'S OCCUPATION | 9. ARE YOU (Check one) ☐ RIGHT HANDED ☐ LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

Yes	No	?	CHECK EACH ITEM	Yes	No	?	CHECK EACH ITEM	Yes	No	?	CHECK EACH ITEM	Yes	No	?	CHECK EACH ITEM
			Household contact with anyone with Tuberculosis				Recurrent ear infections				Adverse reaction to medication				Foot trouble
			Tuberculosis or + test				Chronic/frequent colds				Skin diseases				Nerve injury
			Blood in sputum or cough				Severe tooth/gum prob.				Tumor/grth/cyst/cancer				Paralysis (Infantile)
			Excessive bleeding after Injury or dental work				Sinusitis				Hernia				Epilepsy or siezures
			Suicide attempt or plans				Hay fever/Diergicrhinitis				Hemorrhoids/rectal dis				Car,train,sea sickness
			Sleepwalking				Head injury				Frequent/painful urinate				Trouble sleeping
			Wear corrective lenses				Asthma				Bed wetting to age 12				Depression or excessive worry
			Eye surgery to correct vis				Shortness of breath				Kidney stone/blood ur				Memory loss/Amnesia
			Lack vision in either eye				Pain/pressure in chest				Sexually trans disease				Nervous trouble
			Wear a hearing aid				Chronic cough				Recent gain/loss weight				Periods unconscious
			Stutter or stammer				Palpit'n/pounding heart				Eating disorder				Parent/sibling with Diabetes, cancer, stroke, or heart disease
			Wear brace / back support				Heart trouble				Arthritis,rhumatism,burs				x-ray/radiation therapy
			Scarlet fever				High/Low blood press.				Thyroid/goiter trouble				Chemotherapy
			Rheumatic fever				Cramps in your legs				Bone/Joint deformity				Plate/pin/rod in bone
			Swollen / painful joints				Frequent indigestion				Loss of finger or toe				Easy fatigability
			Frequent/severe headache				Stomach, Liver, or Intestinal trouble				Painful or trick shoulder or elbow				Been told to cut down
			Dizziness / fainting spells				Gall bladder trouble or Gallstones.				Recurrent back pain or any back injury				Or criticized for alcohol use
			Eye trouble				Jaundice or Hepatitis				Trick/locked knee				Used illegal substance
			Hearing loss				Broken bones				Treated female disorder				Used tobacco
			11. FEMALES ONLY												Menstrual change

Check each item YES or NO, every item checked yes must be fully explained on the back.

YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM
		12. Have you ever been refused employment, been unable to hold a job, or stay in school because of:			16. Have you ever been a patient in any type of hospital? *(if yes, specify when, where, why, and name of doctor and complete address of hospital.)*			20. Have you ever been discharged from the military service because of a physical, mental or other reason? *(if yes, give date and reason for discharge, whether honorable, other than honorable, for fitness or unsuitability.)*
		a. Sensitivity to chemicals, dust, sunlight, etc?						
		b. Inability to perform certain motions?			17. Have you ever consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years for other than minor illnesses? *(if yes, give complete address of doctor, hospital, clinic, and details.)*			21. Have you ever been discharged from the military service because of a physical, mental or other reason? *(if yes, give date and reason for discharge, whether honorable, other than honorable, for fitness or unsuitability.)*
		c. Inability to assume certain positions?						
		d. Other medical reasons ? (give reason)						
		13. Have you ever been treated for a mental condition? *(if yes specify where, when and give details.)*						
		14. Have you ever been denied life insurance? *(if yes state reason and give details.)*			18. Have you ever been rejected for military service because of a physical, mental or other reason? *(if yes, give date and reason for rejection.)*			22. 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, when and why.)*
		15. Have you ever had or have you been advised to have an operation? *(if yes describe and give age at which occurred.)*			19. Have you ever been diagnosed with a learning disability? *(if yes, give type, where and how diagnosed.)*			

22. LIST ALL IMMUNIZATIONS RECEIVED:

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 the purposes of processing my applications for this employment or service.

23a. TYPED OR PRINTED NAME OF EXAMINEE | 23b. SIGNATURE | 23c. DATE

NOTE: HAND TO A DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

24. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA: *(Physician may comment on all positive responses. Physician may develop by interview any additional medical history deemed important, and record significant finding on the back with reference to appropriate entry number.)*

25a. TYPED OR PRINTED NAME OF EXAMINER | 25b. SIGNATURE | 23c. DATE

NYG FORM 6130.2 (Replaces NYG Form 93 which is obsolete)

Version date: 24 Sept 2010 Previous versions obsolete ☐ **Check here if Continuation Sheet is used and enter number of sheets ___**

Print Examiner Medical License Number and Office Address:

NEW YORK GUARD REPORT OF MEDICAL HISTORY

CONTINUATION SHEET

CONTINUATION SHEET NUMBER ____ of ____

MEDICAL RECORD **DATE OF EXAM** DD MM YYYY.

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1. NAME (Last, First, Middle) 2. NYG ID NUMBER 3. GRADE

_____ _____ _____

Include item number(s) from NYG Form 6130.2, Report of Medical History,
and enter additional information below