



STATE OF NEW YORK
DIVISION OF MILITARY AND NAVAL AFFAIRS

NEW YORK NAVAL MILITIA
330 OLD NISKAYUNA ROAD, LATHAM, NEW YORK 12110

SEP 17 2024
NYNMINST 6110.1C

NEW YORK NAVAL MILITIA INSTRUCTION 6110.1C

Subj: PHYSICAL AND MEDICAL REQUIREMENTS

Ref: (a) DMNA Regulation 10-1; Naval Militia Regulations

(b) NYNMINST 1001.1C; Administration Manual

(c) U.S. Army Directive (AD 2023-11)

Encl: (1) Body Mass Index (BMI) Table

(2) Medical Exam and History Forms

1. Purpose. In accordance with references (a) and (b), this instruction promulgates the physical and medical requirements for membership in the New York Naval Militia (NYNM).

2. Cancellation. This instruction cancels NYNMINST 6110.1B, of 17 APR 2015, and NYNMINOTE 6110 of 1 AUG 2023.

3. Direction. Members and applicants of the NYNM will follow the guidance in the following areas:

a. The medical requirements of service in the NYNM are the same as that of the individual's parent Federal Reserve component. Arduous physical activity may be required. All members must be able to run/walk one (1) mile in less than 20 minutes and be able to lift or carry up to 40 pounds on a frequent basis.

b. Physical Examination Requirements:

(1) Selected Reserve (SELRES) and Individual Ready Reserve (IRR) members of the United States Navy, Marine Corps, or Coast Guard must maintain all physical and health requirements of their parent Federal service. Copies of all medical documentation are maintained by the parent service. If a member is physically qualified (PQ) as a SELRES, then no additional documentation is required. IRR members must forward a copy of their annual Physical Health Assessment (PHA) to NYNM Headquarters or complete the annual medical evaluation requirements of 900-series members described below.

(2) Members of the NYNM who are no longer SELRES or IRR must have on file a current (within the past 400 days) record of a medical evaluation as delineated below. Upon completion of the medical evaluation, members must forward a copy of the applicable forms by mail or electronically (using a secure method) to NYNM Headquarters to update their service record and database. The NYNM Force Medical

Officer or their authorized representative, will administratively review all submissions for completeness and accuracy, and endorse submissions as indicated. Members who are required to submit medical documentation to NYNM Headquarters will do so at their own expense. Individuals evaluated under the medical requirements of this instruction will be classified as either:

(a) Physically Qualified (PQ). Medical examiners will report those individuals as PQ who have met the medical requirements of the NYNM, as delineated on NYNM Form 88. No individuals will be accepted as being PQ on a provisional basis pending treatment or correction of a disqualifying condition.

(b) Not Physically Qualified (NPQ). Medical examiners will report those individuals as NPQ who have not met the medical requirements of the NYNM as the result of a disqualifying condition. The medical examiner shall differentiate between permanent NPQ and temporary NPQ status.

(3) Forms for recording a member's medical history (NYNM Form 93) and physical examination (NYNM Form 88) are found in enclosure (2).

(4) The components and frequency of medical evaluations include:

(a) Medical History: Members of the NYNM that are no longer SELRES or IRR shall complete NYNM Form 93 (Report of Medical History) prior to the medical examination. This form shall be reviewed by the medical examiner for completeness and accuracy.

(b) Physical Examination: A physical examination for members that are no longer SELRES or IRR must be conducted by a licensed physician or other appropriately credentialed healthcare provider at the member's own expense. In some cases, a military medical specialist may conduct the examination as designated by the Commander, NYNM. NYNM Form 88 must be completed, signed, and dated by a licensed or other appropriately credentialed medical examiner.

(5) All applicants for membership who are no longer SELRES or IRR must submit a completed NYNM Form 88 and NYNM Form 93 to NYNM Headquarters either by mail or electronically before affiliation will be considered. All applicants that are IRR must submit a copy of their most recent PHA or a completed NYNM Form 88 and NYNM Form 93 to NYNM Headquarters either by mail or electronically before affiliation will be considered.

c. Height and Weight Body Mass Index (BMI) Standards

(1) The established standard for membership in the NYNM is a BMI less than 31. New accessions must generally meet this standard. However, waivers are possible for candidates offering needed and extraordinarily valuable experience identified in their *Civilian-Military Skills Questionnaire, NYNMFORM 1070*, during the application process.

(2) Members exceeding the established standard with a BMI of 31 to less than 35 are eligible for state active duty. Members with a BMI of 35 or greater are not eligible for state active duty.

(3) All members that are no longer SELRES or IRR applying for enlistment or applying for an officer appointment, must meet the established standards as set forth in Enclosure (1).

(4) All members will have height and weight recorded as part of their latest medical exam.

(5) Members must have a US National Institute of Health (NIH) or Centers for Disease Control (CDC) BMI calculation, or body fat measurement within service standards. BMI will be assessed annually for 900-series members upon submission of Annual Medical exam. Optionally, a bodyfat measurement may be submitted by the member in cases where BMI is greater than established standards. The optional bodyfat measurement must be performed at the member's expense. Bodyfat standards are promulgated by reference (c). The individual must, at their own expense, coordinate with a medical or military professional familiar with reference (c) to determine a bodyfat percentage within the standards identified by gender and age as above. A memo on letterhead of the above professional indicating the bodyfat measurement and calculation must be submitted by the member for evaluation by the Force Medical Officer.

(6) Failure to meet established standards: Waivers to BMI standards may be authorized by the Commander, NYNM, in the best interest of the service for those applying for enlistment or appointment as an officer, with prior approval by the New York State Adjutant General. This waiver authority may not be delegated.

d. In the event of mobilization or other State Active Duty assignment, a pre-mobilization screening will be conducted to ensure that a current physical exam record is on file, attesting to the member's ability to perform arduous duty as stated in this instruction.

4. Enclosure (1) is a BMI table from the NIH. Actual BMI should be calculated individually from the CDC Control web site calculator:
https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

5. Enclosure (2) includes the NYNM forms for Report of Medical Examination (NYNMF088) and Report of Medical History (NYNMF093).


M. F. PERRY

BODY MASS INDEX (BMI) TABLE

Height is measured in stocking feet without shoes or boots, standing on a flat surface with the chin parallel to the floor. The body should be straight but not rigid, similar to the position of attention. The measurement will be rounded as follows:

If the fraction is less than $\frac{1}{2}$ inch, round down to the next whole number.

If the fraction is more than $\frac{1}{2}$ inch, round up to the next whole number.

Weight is measured and recorded to the nearest pound following these guidelines:

If the fraction is less than $\frac{1}{2}$ pound, round down to the next whole number.

If the fraction is more than $\frac{1}{2}$ pound, round up to the next whole number.

This table is designed for weight measurements taken in a standard PT uniform (gym shorts and T-shirt; without shoes). Alternatively, measurements may be taken in civilian clothes or a utility uniform consisting of blouse, trousers, belt, undershirt, underwear, and socks without boots. In this case, subtract 5 pounds from the measured weight to calculate the member's equivalent weight.

Body Mass Index Table																																				
Normal							Overweight					Obese										Extreme Obesity														
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Body Weight (pounds)																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.

REPORT OF MEDICAL EXAM

PRIVACY ADVISORY STATEMENT

NEW YORK NAVAL MILITIA

Health and Medical Personal Information

AUTHORITY FOR COLLECTION OF PERSONAL INFORMATION: Personal Privacy Protection Law of New York State; Privacy Act of 1974, 5 U.S. Code, sections 552-522a.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION: The requested information is mandatory for New York Naval Militia (NYNM) members to insure that: (1) medical record information is accurate for the individual member; and (2) to document all active duty medical incidents in view of future rights and benefits. If the requested information is not furnished, the NYNM member will not be considered for assignment for routine or emergency state active duty. If a NYNM member currently serving on routine or emergency state active duty declines to provide the requested information, the NYNM member's assignment to routine or emergency state active duty may be terminated.

ROUTINE USES: This all inclusive Privacy Act Statement will apply to all requests for personal information made by the New York Naval Militia and applicable health care providers, or for medical treatment purposes. It will become part of your New York Naval Militia service record. The intended use is in order to maintain a rapid recall capability, emergency notification, and to facilitate and document your health care.

PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED: The primary use of this information is to identify NYNM members who are physically capable of conducting routine and/or arduous tasks that may arise during the performance of state active duty. This form provides you the advice required by the New York State Personal Privacy Act and the federal Privacy Act of 1974.

THIS FORM IS NOT A CONSENT FORM TO RELEASE PERSONAL INFORMATION PERTAINING TO YOU TO AGENCIES AND ENTITIES OUTSIDE OF THE NEW YORK STATE DIVISION OF MILITARY AND NAVAL AFFAIRS AND THE JOINT FORCES OF THE NEW YORK STATE ORGANIZED MILITIA.

New York Naval Militia (NYNM)	REPORT OF MEDICAL EXAM	FOR OFFICIAL USE ONLY NYNM Form 88
INSTRUCTIONS TO MEDICAL PROFESSIONAL		
<p>The applicant may be participating in strenuous activity, which may include exposure to extreme weather conditions, cold water, fatigue and remote locations. Please, complete the following items and summarize your findings in the section below. By your signature, you have determined that the applicant is fit for full duty in the New York Naval Militia.</p> <p>Medical examinations recorded on another agency or organizational record of medical examination form, with signature of licensed medical practitioner are acceptable in lieu of this completed form. Attach the completed other agency form to this form, and complete sections 1 and 2 below.</p> <p>Acceptance criteria for applicants to the New York Naval Militia include the ability to FULLY participate in militia activities. This includes strenuous physical exercise and activities. Defects that are cause for rejection of an applicant for actual enlistment or appointment into the naval service should be identified. Conditions that will or are likely to require treatment, particularly unresolved injuries and recurrent illness must be listed. The history of immunization should be verified to the satisfaction of the medical examiner. A licensed healthcare provider must complete this examination.</p>		
1. UNIT INFORMATION		
1a. Unit Name		1b. NYNM Region
2. PERSONNEL INFORMATION		
2a. Last Name		2b. First Name
2c. MI		2d. Blank
2e. Age	2f. Date of Birth (DD MMM YY)	2g. Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X
2h. Emergency Contact Person Name and Phone Number		
2i. Home Address		2j. City
2k. State		2l. Zip Code + 4
2m. Home Phone	2n. Date of Physical Examination (DD MMM YY)	2o. Location of Physical Examination
3. CLINICAL EVALUATION		
	Normal	Abnormal
3a. Head, Face, Neck, and Scalp	<input type="checkbox"/>	<input type="checkbox"/>
3b. Nose	<input type="checkbox"/>	<input type="checkbox"/>
3c. Sinuses	<input type="checkbox"/>	<input type="checkbox"/>
3d. Ears – General (<i>Internal and External Canals</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3e. Ear Drum (<i>Perforation</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3f. Eyes- General	<input type="checkbox"/>	<input type="checkbox"/>
3g. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>
3h. Pupils (<i>Equality and Reaction</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3i. Heart (<i>Thrust, Size, Rhythm, and Sounds</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3j. Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>
3k. Abdomen and Viscera (<i>Include Hernia</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3l. External Genitalia (<i>Genitourinary</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3m. Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>
3n. Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>
3o. Feet	<input type="checkbox"/>	<input type="checkbox"/>
3p. Spine and other Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
	Normal	Abnormal
3q. Mouth and Throat	<input type="checkbox"/>	<input type="checkbox"/>
3r. Vascular System (<i>Varicosities, etc.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3s. Prostate	<input type="checkbox"/>	<input type="checkbox"/>
3t. Testicular	<input type="checkbox"/>	<input type="checkbox"/>
3u. Anus and Rectum	<input type="checkbox"/>	<input type="checkbox"/>
3v. Endocrine System	<input type="checkbox"/>	<input type="checkbox"/>
3w. G-U System	<input type="checkbox"/>	<input type="checkbox"/>
3x. Skin, lymphatics	<input type="checkbox"/>	<input type="checkbox"/>
3y. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>
4. LABORATORY FINDINGS (as clinically indicated)		
4a. Urinalysis (1) Albumin: (2) Sugar:		4b. Blood (1) Hemoglobin: (2) Hematocrit:
5. MEASUREMENTS AND OTHER FINDINGS		
5a. Height inches	5b. Weight lbs.	5c. Obese <input type="checkbox"/> Yes <input type="checkbox"/> No
5d. Pulse		5e. Blood Pressure (1) Systolic: (2) Diastolic:
5f. Blank		5g. Wears Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No
		5h. Wears Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No
		5j. Best/Corrected Vision (1) Left: 20/ (2) Right: 20/
		5k. Or valid NYS Driver License Number/Class
5l. Other Findings (if more room is needed, continue on reverse)		

Last Name	REPORT OF MEDICAL EXAM	NYNM Form 88 (Reverse)
6. NOTES, REMARKS, AND OTHER FINDINGS (Use additional sheets of paper if needed)		
ACCEPTANCE CRITERIA FOR APPLICANTS TO, AND CONTINUED SERVICE IN THE NEW YORK NAVAL MILITIA		
<p>A. Acceptance is based upon ability to participate in strenuous physical activity, (which may include exposure to extreme weather conditions, cold water, fatigue and remote locations) and the absence of contagious disease, illness, or history that will or is likely to require medical care or restriction of participation. All members must be able to run/walk one (1) mile in less than 20 minutes and be able to lift or carry up to 40 pounds on a frequent basis.</p> <p>B. Special attention should be given to orthopedic and cardiovascular conditions or complaints.</p> <p>C. There is no specific limit for vision. However, applicants who wear glasses or contact lenses but cannot participate in activities that require the removal of glasses (or contacts) should be reviewed on a case-by-case basis.</p> <p>D. Examining physicians may submit appropriate statements for consideration of acceptance, when the physician is of the opinion that the applicant will not encounter any restriction of participation in the program and that the condition in question does not present an unacceptable risk for aggravation or worsening as the result of participation in the activities of the New York Naval Militia.</p>		
7. ENDORSEMENT		
It is my professional medical opinion in accordance with the above criteria that the examinee is:		
<input type="checkbox"/> PHYSICALLY QUALIFIED: Fit for full duty in the New York Naval Militia		
<input type="checkbox"/> NOT PHYSICALLY QUALIFIED: NOT fit for full duty for reasons stated above in Block 6 (notes)		
7a. Name of Physician (Type or Print) or Physician's Stamp	7b. Signature	7c. Date (DD MMM YY)

NYNM 88 (REV 08/22) Reverse

New York Naval Militia, 330 Old Niskayuna Road, Latham, New York 12110

Enclosure (2)

PRIVACY ADVISORY STATEMENT

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Health and Medical Personal Information

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New York Naval Militia (NYNM)	REPORT OF MEDICAL HISTORY AUTHORIZATION, CONSENT AND RELEASE	FOR OFFICIAL USE ONLY NYNM Form 93																		
NOTICE																				
<p>The information requested below is required to provide the medical examiner an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the New York Naval Militia. Also this information will be provided to medical examiners in case of injury or illness. <u>If taking medications at time of application, list in Block 6.</u></p> <p>THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE. You are encouraged to consult your private medical provider regarding past illnesses.</p>																				
1. UNIT INFORMATION																				
1a. Unit Name		1b. NYNM Region																		
2. PERSONAL INFORMATION																				
2a. Last Name		2b. First Name																		
2c. MI		2d. Blank																		
2e. Age	2f. Date of Birth	2g. Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X																		
2h. Emergency Person Contact Name and Phone Number																				
2i. Home Address		2j. City																		
2k. State	2l. Zip Code	2m. Home Phone																		
2n. Date of Physical Examination (DD MMM YY)																				
3. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 6: explain treatment to return member to medically fit for duty)																				
HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:		YES NO																		
3a. Tuberculosis or live with someone with tuberculosis		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3b. Chronic or recurrent abdominal or stomach pain		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3c. Asthma or breathing problems related to exercise, pollen, etc.		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3d. Been prescribed or use an inhaler		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3e. Loss of vision in either eye		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3f. Loss of hearing or wear a hearing aid		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3g. Impaired use of arms, legs, hands, feet		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3h. Knee problems		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3i. Broken bones(s) (cracked or fractured)		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3j. Diabetes		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3k. Anemia (including sickle cell)		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3l. Dizziness or fainting spells (including after exercise)		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3m. Head injury or concussion		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3n. Seizures, convulsions, epilepsy, or fits		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3o. Car, train, sea, and/or air sickness		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3p. A period of unconsciousness		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3q. Heart trouble or murmur		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3r. Received counseling for emotional or behavior disorder		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3s. Eating disorder (bulimia, anorexia)		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3t. Sleepwalking		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3u. Frequent or severe headaches		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3v. Been hospitalized (if yes, why, when, where)		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3w. Any illness or injury not mentioned above (if yes, explain)		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
3x. Advised to avoid certain physical activities (if yes, explain)		<input type="checkbox"/> YES <input type="checkbox"/> NO																		
4. IMMUNIZATION RECORDS																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 33%;">IMMUNIZATIONS</th> <th style="width: 33%;">Month/Year Given</th> <th style="width: 33%;">Month/Year Given</th> </tr> <tr> <td>Tetanus</td> <td>____/____</td> <td>Mumps</td> </tr> <tr> <td>Diphtheria</td> <td>____/____</td> <td>Rubella</td> </tr> <tr> <td>Pertussis</td> <td>____/____</td> <td>Polio</td> </tr> <tr> <td>Measles</td> <td>____/____</td> <td>Chicken Pox</td> </tr> <tr> <td>Small Pox</td> <td>____/____</td> <td>Influenza</td> </tr> </table>			IMMUNIZATIONS	Month/Year Given	Month/Year Given	Tetanus	____/____	Mumps	Diphtheria	____/____	Rubella	Pertussis	____/____	Polio	Measles	____/____	Chicken Pox	Small Pox	____/____	Influenza
IMMUNIZATIONS	Month/Year Given	Month/Year Given																		
Tetanus	____/____	Mumps																		
Diphtheria	____/____	Rubella																		
Pertussis	____/____	Polio																		
Measles	____/____	Chicken Pox																		
Small Pox	____/____	Influenza																		

REPORT OF MEDICAL HISTORY		NYNM Form 93
5. ALLERGIES (Mark each item "YES" or "NO" Every item marked yes must be fully explained in block 5i)		
DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:	YES NO	YES NO
5a. Bee or Wasp Sting	<input type="checkbox"/> <input type="checkbox"/>	5e. Latex
5b. Hay Fever or seasonal allergies	<input type="checkbox"/> <input type="checkbox"/>	5f. Any drug, E-mycin antibiotic, or sulfa allergies, list in Block 5i
5c. Insect Bites	<input type="checkbox"/> <input type="checkbox"/>	5g. Other Allergies, list in Block 6
5d. Iodine/seafood	<input type="checkbox"/> <input type="checkbox"/>	5h. Food allergies, list in Block 6
5i. Describe the allergic reaction and what condition occurs:		
6. Remarks (Please include comments as required by Block 3. Also provide any other medical history that you or your physician deems important.)		
List all current medications, including over-the-counter medications, vitamins, and supplements;		
Social History:		
Tobacco Use: Number of packs or dips per day: _____		
Alcohol Use: Number of drinks per week (on average): _____		
List all current medical restrictions:		
Have there been any significant changes in your health since your last medical examination: <input type="checkbox"/> NO <input type="checkbox"/> YES. If YES, please describe:		
7. AUTHORIZATION AND RELEASE		
I certify that to the best of my knowledge the information provided is true and accurate and that I have disclosed all pertinent medical history.		
8a. Member Name (Type or Print)	8b. Signature	8c. Date