

**Georgia State Defense Force
1ST BRIGADE MEDICAL DETACHMENT**

RECORDS OF:

Last Name,	First Name,	MI.
Review Dates:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WARNING

THESE ARE CONFIDENTIAL MEDICAL AND HEALTH HISTORY RECORDS AND MAY BE IN THE POSSESSION OF OR MAY BE VIEWED BY ONLY PERSONNEL OF THE GEORGIA STATE DEFENSE FORCE 1ST BRIGADE MEDICAL DETACHMENT OR BY THOSE AUTHORIZED PERSONNEL OF THE GEORGIA DEPARTMENT OF DEFENSE OR THE GEORGIA STATE DEFENSE FORCE. NEITHER THESE RECORDS NOR THE FINDINGS OF THESE RECORDS WILL BE RELEASED IN WHOLE OR IN PART TO ANY OUTSIDE PERSON, ENTITY, AGENCY, FACILITY OR SIMILAR ORGANIZATION WITHOUT THE EXPRESS WRITTEN PERMISSION OF THE PERSON NAMED WITHIN.

Medical History-Health History- Exercise History
Georgia State Defense Force 1st Brigade Medical Detachment

FORM
HH0202 MEDDET

Privacy Act Statement

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

PRINCIPAL PURPOSE(S): To obtain medical data, medical history, general health history, and exercise history for determination of general fitness for various categories of State Defense Force service. This information will be used by the officers and staff of the Georgia State Defense Force 1st Brigade Medical Detachment as well as others authorized with a need to know within the Georgia State Defense Force and the Georgia Department of Defense.

This information will not be released to or otherwise disseminated to anyone outside of the Georgia State Defense Force 1st Brigade Medical Detachment, Georgia State Defense Force or Georgia Department of Defense without your written authorization.

ROUTINE USE(S): None

DISCLOSURE: Voluntary. You are volunteering this information. You are not required to provide this information. Should you chose not to provide this information, you will be assigned a category of service of Medical Profile, limiting the amount of physical requirements for your service in the Georgia State Defense Force.

WARNING: The information you are providing constitutes an official statement. It is essential that you are accurate and provide the necessary details as required. Failure to do so could cause assignments to service categories or duty levels which could be potentially harmful to you. Failure to supply correct and complete information will result in an automatic assignment of service to Medical Profile as well as other potential administrative or punitive actions.

1. LAST NAME, FIRST NAME, MI			2. SOCIAL SECURITY NUMBER		3. TODAY'S DATE (YYYYMMDD)	
4.a. HOME ADDRESS (Street, apartment no., City, State, and ZIP Code)			4.a. Home Telephone Number		5. BIRTHDATE(YYYYMMDD)	
			4.b. Bus. Telephone Number		6. BLOOD TYPE	
7. UNIT OF ASSIGNMENT IN GaSDF			4.c. email address			
			8. RANK			9. GRADE
11. YOUR USUAL CIVILIAN OCCUPATION (be specific)			12. EMERGENCY CONTACT (Name, Relationship, Contact numbers – telephone, pager, cell phone)			
13. CURRENT MEDICATION (Prescription and Over-the-counter)			14. ALLERGIES (Including insect bites/sting, food, medicine or other substances)			

Mark each item "YES" or "NO". Every item marked "yes" must be fully explained on Page 4 (by question number)

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
14. a. Tuberculosis or lived with someone who had TB			15. a. Severe tooth or gum trouble		
b. Coughed up blood			b. Eye disorder or trouble		
c. Asthma or any breathing problems related to exercise, weather, pollens, etc.			c. Ear, nose or throat trouble		
d. Shortness of breath			d. Loss of vision in either eye		
e. Bronchitis			e. Worn contact lenses or glasses		
f. Wheezing or problems with wheezing			f. A hearing loss or wear a hearing aid		
g. Been prescribed or used an inhaler			g. Surgery to correct vision (RK, PRK, LASIK, etc.)		
h. A chronic cough or cough at night					
i. Sinusitis					
j. Hay fever					
k. chronic or frequent colds					

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LAST NAME,	FIRST NAME,	MI	SOCIAL SECURITY NUMBER
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Mark each item "YES" or "NO". Every item marked "yes" must be fully explained on Page 4 (by question number)

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
16.a. Painful shoulder, elbow or wrist (pain, dislocation)			20.a. Nervous trouble of any sort (anxiety or panic attacks)		
b. Recurrent back pain or any back problem			b. Habitual stammering or stuttering		
c. Numbness or tingling			c. Loss of memory or amnesia or neurological symptoms		
d. Loss of finger or toe			d. Frequent trouble sleeping		
e. Foot trouble (e.g. pain, corns, bunions, etc.)			e. Received counseling of any type		
f. Arthritis, rheumatism, or bursitis			f. Depression or excessive worry		
g. Impaired use of arms, legs, hands or feet			g. Been evaluated or treated for a mental condition		
h. Swollen or painful joint(s)			h. Attempted suicide		
i. Knee trouble (e.g. locking, giving out, pain or ligament injury etc.)			i. Used illegal drugs or abused prescription drugs		
j. Any knee or foot surgery including arthroscopy					
k. Any need to use corrective devices (prosthetics, braces, back supports, lifts or orthotics, etc.)			21. FEMALES ONLY. Have you ever or do you now have		
l. Bone, joint or other deformity			a. Treatment for a gynecological (female) disorder		
m. Plate(s), screw(s), rod(s), pin(s) in any bone			b. A change of menstrual pattern		
n. Broken bone(s) (cracked or fractured)			c. Any abnormal PAP smears		
			22. Have you been refused employment or been unable to hold a job or stay in school because of:		
17. a. Frequent indigestion or heartburn			a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Stomach, liver, intestinal trouble, or ulcer			b. Inability to perform certain motions		
c. Gall bladder trouble or gallstones			c. Inability to stand, sit, kneel, lie down, etc		
d. Jaundice or hepatitis (liver disease)			d. Other medical reason (if yes, give reasons)		
e. Rupture/hernia			23. Have you ever been treated in an Emergency Room? If yes, for what?		
f. Rectal disease, hemorrhoids or blood from the rectum					
g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)			24. Have you ever been a patient in any type of hospital? If yes, Specify when, where, why you were patient.		
h. Frequent or painful urination					
i. High or low blood sugar			25. Have you ever had, or have you been advised to have any Operations or surgery? If yes, describe and give age at which occurred.		
j. Kidney stone or blood in urine					
k. Sugar or protein in urine			26. Have you ever had any illness or injury other than those already Noted? If yes, specify when, where and give details.		
l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)					
18. a. Adverse reaction to serum, food, insect stings or medicine			27. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? If yes, give complete details.		
b. Recent unexplained gain or loss of weight					
c. Do you feel UNFIT either physically or medically			28. Have you ever been discharged from military service for any medical or health related reason? If yes, give date, reason, and type of discharge.		
d. Tumor, growth, cyst, or cancer					
19. a. Dizziness or fainting spells			29. Have you ever been rejected for military service for any medical or health related reason? If yes, give date and reason for rejection		
b. Frequent or severe headache					
c. A head injury, memory loss or amnesia			30. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? If yes, specify what kind, granted by whom and what amount, when, and why.		
d. Paralysis					
e. Seizures, convulsions, epilepsy or fits			31. Have you ever been denied life insurance or other health insurance? If yes, when and why.		
f. Car, train, sea, or air sickness					
g. A period of unconsciousness or concussion			32. Do you use any tobacco products of any kind? If yes, what, how much (packs per day, etc.) and for how long?		
h. Meningitis, encephalitis, or other neurological problems					
			33. Do you consume alcohol? If yes, how often, how much and for how long?		
20.a. Rheumatic fever					
b. Prolonged bleeding (as after an injury or tooth extractions)					
c. Pain or pressure in the chest					
d. Palpitation, pounding heart or abnormal heartbeat					
e. Heart trouble or murmur					
f. High or low blood pressure					

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LAST NAME,

FIRST NAME,

MI

SOCIAL SECURITY NUMBER

DETAIL ANSWER SECTION—PROVIDE DETAILS TO ALL QUESTIONS WHICH WERE ANSWERED YES AND REQUIRED ADDITION DETAILS. BE THOROUGH. START EACH ANSWER WITH THE NUMBER AND LETTER OF THE REFERENCED QUESTION

QUESTION
NUMBER

DETAILS

IMPORTANT—YOU MUST READ AND SIGN THIS SECTION. THIS IS APPLICABLE TO ALL WHETHER YOU HAVE VOLUNTARILY PROVIDED INFORMATION OR HAVE DECLINED TO DO SO

I UNDERSTAND THAT THIS INFORMATION IS GIVEN VOLUNTARILY BY ME. FURTHER, I UNDERSTAND THAT IT IS TO BE USED TO HELP IN DETERMINING THE LEVEL OF DUTY IN WHICH I MAY BE ELIGIBLE TO PARTICIPATE. I UNDERSTAND THAT THIS IS NOT TO BE CONSIDERED A FULL MEDICAL EXAMINATION. I FURTHER UNDERSTAND THAT MY CLASSIFICATION AT ANY PARTICULAR LEVEL OF DUTY IS DEPENDENT ON THE COMPLETENESS AND ACCURACY OF THE ANSWERS WHICH I HAVE PROVIDED. I FURTHER AGREE THAT I MAY REQUEST ALTERNATE ASSIGNMENTS TO LEVEL OF DUTY SHOULD I FEEL I AM NOT MEDICALLY OR PHYSICALLY ABLE TO PARTICIPATE AT THE ASSIGNED LEVEL OF DUTY. FURTHER, I AGREE TO INDEMNIFY AND HOLD HARMLESS THOSE WHO EVALUATED AND MADE ASSIGNMENT OF MY DUTY LEVEL AND TO THOSE WHO USED THE ASSIGNED DUTY LEVEL AS MY SUPERIORS.

I FURTHER UNDERSTAND THAT THIS INFORMATION SHALL BE AVAILABLE TO THE OFFICERS AND STAFF OF THE 1ST BRIGADE MEDICAL DETACHMENT OF THE GEORGIA STATE DEFENSE FORCE, AS WELL AS TO OTHER AUTHORIZED PERSONNEL OF THE GEORGIA STATE DEFENSE FORCE AND TO THE GEORGIA DEPARTMENT OF DEFENSE. I FURTHER UNDERSTAND THAT THIS INFORMATION SHALL NOT BE PROVIDED TO ANY INDIVIDUAL, CLINIC, HOSPITAL, AGENCY OR OTHER SUCH ORGANIZATION WITHOUT MY EXPRESS WRITTEN PERMISSION.

SIGNED : _____ DATED: _____

WITNESS: _____ DATED: _____

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MEDICAL PROFILE Georgia State Defense Force 1st Brigade Medical Detachment		
LAST NAME,	FIRST NAME, MI	SOCIAL SECURITY NUMBER
MEDICAL PROFILE STATEMENT AND CONDITIONS— STATEMENT OF MEDICAL PROFILE, LIMITATIONS IMPOSED BY PROFILE, DISPOSITION AND/OR EXPECTED RELEASE FROM PROFILE IF TEMPORARY PROFILE. THIS IS AN OFFICIAL RECORD COPY: 1BDE MEDET—1BDE CO—1BDE XO—1BDE 3-1—UNIT OF ASSIGNMENT COMMAND—INDIVIDUAL		
DATE	PROFILE DESCRIPTION	
By: Name (Print) _____ Social Security Number _____ Grade/Rank _____ Unit: _____ Position: _____ Signature: _____		

