SUPPLEMENTAL MEDICAL HISTORY FORM

APPLICANTS: Complete all portions of this form. **Failure to answer any questions or disclose a known medical condition or failure to place signature where indicated may result in disqualification from employment consideration.** Please print or type. Each "yes" answer to a medical history question requires that you provide a brief explanation in the comment section. This examination is being conducted for employment purposes only; it does not substitute for a periodic health examination conducted by your private provider.

ATTENTION VETERANS/SERVICE MEMBERS: Even though some versions of the Questionnaire for National Security Positions (SF-86) may not require you to disclose some types of mental health counseling, **all mental health counseling must be disclosed on this Medical Examination and History Report form in order to determine if you meet the minimum medical qualifications for the position.**

I have read and understand these instructions. **APPLICANT SIGNATURE**: _____

APPLICANT'S NAME (Last, First, Middle Initial):

SEX: Male ☐ Female ☐	DATE OF BIRTH: (mm/dd/yy)	SOCIAL SECURITY NUMBER (or APPLICANT ID):

CHECK THE OCCUPATION FOR WHICH YOU ARE BEING CONSIDERED:

☐ Border Patrol Agent
☐ Customs and Border Protection Officer
☐ Marine Interdiction Agent
☐ Other:_____

MEDICAL HISTORY

	Have you experienced any of the following?	Check one.	Explain all "yes" responses.
1	Diabetes	☐ Yes ☐ No	If yes, circle treatment: diet pills insulin
2	Blood disorder	☐ Yes ☐ No	
3	Anemia	☐ Yes ☐ No	
4	Phlebitis or blood clots	☐ Yes ☐ No	
5	Lack of coordination, dizziness or balance issues	☐ Yes ☐ No	
6	Tremors/shakiness	☐ Yes ☐ No	
7	Loss of sensation	☐ Yes ☐ No	
8	Crohn's Disease, Colitis, or Irritable Bowel Syndrome	☐ Yes ☐ No	
9	Sleep disorders	☐ Yes ☐ No	
10	Sleep apnea/sleep study	☐ Yes ☐ No	
11	Organ transplant (e.g. kidney, etc.)	☐ Yes ☐ No	
12	Heat stroke/heat exhaustion	☐ Yes ☐ No	
13	Heart surgery	☐ Yes ☐ No	
14	Stroke	☐ Yes ☐ No	
15	Asthma (after age 12)	☐ Yes ☐ No	
16	Corneal Refractive Therapy (CRT lenses)/ orthokeratology	☐ Yes ☐ No	
17	Mental health treatment or counseling	☐ Yes ☐ No	
18	Diagnosed with depression, anxiety, or PTSD	☐ Yes ☐ No	
19	ADD/ADHD	☐ Yes ☐ No	
20	Have you ever applied for, or received, pension or compensation for a disability? (VA, Social Security, Workers' Compensation, etc.)	☐ Yes ☐ No	

MEDICAL HISTORY (CONTINUED)		
21	Over the past six weeks, on average, how many times per week have you been running?	_____times per week
22	What distance do you run each time?	_____miles
23	How many minutes do you usually run without stopping?	_____minutes
24	Describe the level of your current physical activity or exercise program	Circle one. Low intensity Moderate Intensity High Intensity
25	How many days per week do you exercise?	_____days per week
26	How long do you exercise on those days?	_____minutes per session
27	Describe your exercise activities:	_____ _____
28	Do you have any lifting restrictions (that is, has your doctor told you not to lift over a certain number of pounds because of a medical issue)?	☐ Yes ☐ No If yes, indicate the number of pounds you are allowed to lift, and the reason for the restriction. _____ _____
29	Have you had any changes in your health status (injuries, issues, conditions or treatments) since you completed your military separation forms (DD Forms 2807-1 and 2808)?	☐ Yes ☐ No If yes, describe: _____ _____

I certify that the above information provided is complete and correct to the best of my knowledge. I authorize any of the doctors, hospitals or clinics mentioned on these pages to furnish my complete medical record to the Federal Agency (and its authorized Medical Review Officer) for purposes of determining if I am medically qualified for the position for which I have applied.

APPLICANT'S SIGNATURE: DATE: