

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
STATEMENT OF HISTORY REGARDING HEAD INJURY**

*Form Approved
OMB No. 0704-0396
Expires Sep 30, 2006*

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0396). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO DODMERB/DR, 8034 EDGERTON DRIVE, SUITE 132, USAF ACADEMY CO 80840-2200.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397.

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applications to their Academies.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1. NAME OF APPLICANT (*Last, First, Middle Initial*)

2. SSN OF APPLICANT

INSTRUCTIONS

Please answer the following questions regarding head injury. Be very specific in your answers. If additional space is needed, please use the reverse side of this form.

3. HOW DID THE HEAD INJURY OCCUR?

4. HOW OLD WERE YOU WHEN IT HAPPENED?

5. DID YOU EXPERIENCE LOSS OF CONSCIOUSNESS OR AMNESIA? IF SO, HOW LONG?

6. DID YOU HAVE X-RAYS OR WERE YOU SEEN IN A HOSPITAL? IF SO, SEND COPIES OF MEDICAL RECORDS.

7. DID YOU HAVE ANY SYMPTOMS AFTER THE INJURY, FOR EXAMPLE; HEADACHES, VOMITING, DISORIENTATION, DOUBLE VISION, DIZZINESS, ETC.? HOW LONG DID THE SYMPTOM(S) LAST?

8. WERE ANY ADDITIONAL PROCEDURES ACCOMPLISHED SUCH AS ELECTROENCEPHALOGRAM, BRAIN SCAN, BURR HOLES, PNEUMOENCEPHALOGRAM, ETC.?

9. SIGNATURE OF APPLICANT

10. DATE SIGNED