FD-1065
Revised
7-27-2011

FEDERAL BUREAU OF INVESTIGATION
REPORT OF MEDICAL HISTORY

Privacy Act Statement: The collection of this information on this form, which is authorized by 5 U.S.C. § 301 and 5 U.S.C. § 3301, is relevant and necessary to provide appropriate medical care and to determine eligiblity and/or fitness for duty. Completion of this form is voluntary; however, your failure to supply all the information requested on this form may impede or preclude agency action regarding medical care or continued employment.

GINA Notice: Do Not Provide Genetic Information, Including Family Medical History

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *See* 29 C.F.R. § 1635.8(b)(1)(i)(B).

This infomation is maintained in your medical file in the FBI Centeral records System, Justice/FBI-002, a description of which can be found at http://home.fbinet.fbi/DO/OGC/LTB/PCLU/PrivacyCivil%20Liberties%20Library/Forms/FBI002.aspx. This information may be disclosed in accordance with the routine uses referenced in this notice.

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/67#	3. Grade
4. Division/Field Office Address	4a. Examining Facility	
4b. City	4c. State	4d. Zip Code
5. Purpose of Examination		
5a. Height / 5b. Weight	6. Are you (Check One) ☐ Right Handed ☐ Left Handed	

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

8. Present Health	8a. Current Medication	8b. Regular or Interm.
8c. Occupation		
9. Allergies (Include insect bites/stings and common foods)		

10. PAST/CURRENT MEDICAL HISTORY

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household contact with anyone with tuberculosis	☐	☐	☐	Eye surgery to correct vision	☐	☐	☐	Swollen or painful joints	☐	☐	☐
Tuberculosis or positive TB test	☐	☐	☐	Lack vision in either eye	☐	☐	☐	Frequent or severe headaches	☐	☐	☐
Blood in sputum or when coughing	☐	☐	☐	Wear a hearing aid	☐	☐	☐	Dizziness or fainting spells	☐	☐	☐
Excessive bleeding after injury or dental work	☐	☐	☐	Wear a brace or back support	☐	☐	☐	Eye trouble	☐	☐	☐

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Suicide attempt or plans	☐	☐	☐	Stutter or stammer	☐	☐	☐	Hearing loss	☐	☐	☐
Sleepwalking	☐	☐	☐	Scarlet fever	☐	☐	☐	Recurrent ear infections	☐	☐	☐
Wear corrective lenses	☐	☐	☐	Inability to assume certain positions	☐	☐	☐	"Trick" or locked knee	☐	☐	☐
Severe tooth or gum trouble	☐	☐	☐	Rheumatic fever	☐	☐	☐	Chronic or frequent colds	☐	☐	☐
Sinusitis	☐	☐	☐	Tumor, growth cyst, cancer	☐	☐	☐	Foot trouble	☐	☐	☐
Hay fever or allergic rhinitis	☐	☐	☐	Hernia	☐	☐	☐	Nerve Injury	☐	☐	☐
Head injury	☐	☐	☐	Hemorrhoids or rectal disease	☐	☐	☐	Paralysis (including infantile)	☐	☐	☐
Asthma	☐	☐	☐	Frequent or painful urination	☐	☐	☐	Epilepsy or seizure	☐	☐	☐
Shortness of breath	☐	☐	☐	Bed wetting since age 12	☐	☐	☐	Car, train, sea or air sickness	☐	☐	☐
Pain or pressure in chest	☐	☐	☐	Kidney stone or blood in urine	☐	☐	☐	Frequent trouble sleeping	☐	☐	☐
Chronic cough	☐	☐	☐	Sugar or albumin in urine	☐	☐	☐	Depression or excessive worry	☐	☐	☐
Palpitation or pounding heart	☐	☐	☐	Sexually transmitted diseases	☐	☐	☐	Loss of memory or amnesia	☐	☐	☐
Heart trouble	☐	☐	☐	Recent gain or loss of weight	☐	☐	☐	Nervous trouble of any sort	☐	☐	☐
High or low blood pressure	☐	☐	☐	Eating disorder (anorexia bulimia, etc.)	☐	☐	☐	Periods of unconsciousness	☐	☐	☐
Cramps in your legs	☐	☐	☐	Arthritis, Rheumatism, or Bursitis	☐	☐	☐	X-ray or other radiation therapy	☐	☐	☐
Frequent indigestion	☐	☐	☐	Thyroid trouble or goiter	☐	☐	☐	Chemotheraphy	☐	☐	☐
Stomach, liver or intestinal trouble	☐	☐	☐	Sensitivity to chemicals, dust, sunlight	☐	☐	☐	Asbestos or toxic chemical exposure	☐	☐	☐
Gall bladder trouble or gallstones	☐	☐	☐	Inability to perform certain motions	☐	☐	☐	Plate, pins or rod in any bone	☐	☐	☐
Jaundice or hepatitis	☐	☐	☐	Bone, joint or other deformity	☐	☐	☐	Easy fatigability	☐	☐	☐
Broken bones	☐	☐	☐	Loss of finger or toe	☐	☐	☐	Been told to cut down or criticized for alcohol use	☐	☐	☐
Adverse reaction to medication	☐	☐	☐	Painful or "trick" shoulder or elbow	☐	☐	☐	Diabetes	☐	☐	☐
Skin diseases	☐	☐	☐	Recurrent back pain or any back injury	☐	☐	☐	Used tobacco	☐	☐	☐

11. FEMALE ONLY						
Check Each Item	Yes	No	Don't Know	Date of Last Menstrual Period	Date of Last Pap Smear	Date of Last Mammogram
Treated for a female disorder	☐	☐	☐			
Change in menstrual pattern	☐	☐	☐			

Check Each Item, If "Yes" Explain in Blank Space To Right. List explanation By Item Number.

Item	Yes	No
12. Have you been treated for a mental condition? If yes, specify when, where, and give details.)	☐	☐
13. Have you been denied life insurance? If yes, state reason and give details.)	☐	☐
14. Have you had, or have been advised to have, any operation? (If yes, describe.)	☐	☐
15. Have you been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	☐	☐
16. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the year, for other than minor illnesses?	☐	☐
17. Do you have a past or current medical history of any other condition not mentioned on this form?	☐	☐
18. 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, and what amount, when, why.)	☐	☐
19. Immunization		

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 purpose of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

20. Typed or Printed Name of Examinee	20a. Signature	20b. Date

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

21. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Item 7 through 11.
Physicians may develop by interview any additional medical history deemed important, and record any significant findings here.

22. Typed or Printed Name of Physician or Examiner	22a. Signature	22b. Date