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**MEDICAL CONDITION FORM**

THE PURPOSE OF THIS FORM IS TO PROVIDE MEDICAL PERSONELL WITH INFORMATION ON ANY EXISTING MEDICAL CONDITIONS, WHICH MAY AFFECT THE MEDICAL CARE AND TREATMENT TO YOU (THE SOLDIER), WHILE ENLISTED IN THE RLA. THIS INFORMATION **WILL NOT** BE VIEWED OR DISCLOSED TO ANYONE OUTSIDE THE MEDICAL STAFF. EMAIL COMPLETED FORM TO COL COMPTON AT “**buford.compton@protonmail.com.”**

**NOTE: ANSWER ALL QUESTIONS HONESTLY AND COMPLETELY, TO THOSE THAT DO NOT APPLY, ANSWER N/A**

**NAME** (LAST, FIRST, MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_

**1.** DO YOU HAVE ANY ALLERGIES?(FOOD, MEDICATIONS, INSECTS, OTHER) IF YES, LIST THE ALLERGY AND YOUR REACTION. (EX. Bee sting – anaphylactic shock) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.** ARE YOU CURRENTLY TAKING ANY MEDICATIONS? IF YES, LIST THE MEDICATIONS, STRENGTH, AND DOSAGE. (EX. Claritan 10mg – once daily)

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**3.** HAVE YOU HAD FLU LIKE SYMPTOMS IN THE PAST 72 HOURS OR FEVER OVER 101? (SYMPTOMS INCLUDE: NAUSEA/VOMITTING, CHILLS, STOMACH PAINS)

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**4.** HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY MEDICAL CONDITIONS? (HYPERTENSION. ASTHMA, PTSD HIGH CHOLESTEROL, etc...)

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**5.** HAVE YOU EVER HAD A WEATHER INJURY? YES( ) NO( ) IF YES, HOT( ) COLD( ) ALSO, LIST THE EXTENT OF THE INJURY AND/OR REACTION AS WELL AS THE DATE IT OCCURRED.

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**6.** HAVE YOU HAD ANY SURGERIES OR SIGNIFICANT INJURIES? (**LIST THEM AND WHEN THEY OCCURRED**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.** LIST ANY IMPORTANT FAMILY HISTORY. (HYPERTENSION, DIABETES, HEART DISEASE, HIGH CHOLESTEROL, STROKE, etc)

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 **8. FEMALES ONLY!!!** HAVE YOU BEEN PREGNANT, DELIVERED, OR HAD A PREGNANCY TERMINATED WITHIN THE LAST 180 DAYS IAW: AR 40-501 PARA 7-10 (e). YES( ) NO( )

WERE YOU CLEARED BY A PHYSICIAN TO RETURN TO DUTY? YES( ) No( ) N/A( )

ROYAL LAO SPECIAL OPERATIONS DEPARTMET