FD-1065 (Rev. 02-03-2014)	REPORT OF MEDICAL HISTORY	DATE COMPLETED

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. DATE OF BIRTH / Age	3. Are you ☐ Right Handed ☐ Left Handed
4. Division/Field Office Address	4a. Examining Facility	
4b. Division City	4c. Division State	4d. Zip Code

5. Purpose of Examination
☐ Fitness for Duty Exam ☐ FD-1065 Interim Update

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

6. Present Health	6a. Current Medications /Dose and Frequency	6b. Allergies (include insect bites/stings and common foods)
7. Job Title/Special Team		

8. PAST/CURRENT MEDICAL HISTORY – Check Each Item; if "YES" Explain in Blank Space on Page 2. List explanation by condition item.

Check each item	Yes	No	Don't know	Check each item	Yes	No	Don't know	Check each item	Yes	No	Don't know
Tuberculosis or positive TB skin test result	☐	☐	☐	Foot trouble (e.g., pain, corns, bunions, etc.)	☐	☐	☐	Frequent or severe headaches	☐	☐	☐
Lived with someone who had tuberculosis	☐	☐	☐	Impaired use of arms, legs, hands, or feet	☐	☐	☐	A head injury, memory loss or amnesia	☐	☐	☐
Coughed up blood	☐	☐	☐	Swollen or painful joint(s)	☐	☐	☐	Seizures, convulsions, epilepsy, fits, or paralysis	☐	☐	☐
Asthma or any breathing problems related to exercise, weather, or pollen	☐	☐	☐	Knee trouble (e.g., locking, giving out)	☐	☐	☐	A period of unconsciousness or concussion	☐	☐	☐
Shortness of breath	☐	☐	☐	Surgery or scope of a joint (Ex: knee, shoulder)	☐	☐	☐	Meningitis, encephalitis, or other neurological problems	☐	☐	☐
Bronchitis	☐	☐	☐	Use of prosthetic device, knee brace/back support	☐	☐	☐	Sexually transmitted disease	☐	☐	☐
Wheezing or problems with wheezing or used an inhaler	☐	☐	☐	Bone, joint, or other deformity	☐	☐	☐	Prolonged bleeding (as after an injury or tooth extractions)	☐	☐	☐
A chronic cough or cough at night	☐	☐	☐	Plate, screw, rod or pin in any bone	☐	☐	☐	Pain or pressure in the chest	☐	☐	☐
Sinusitis	☐	☐	☐	Broken bone(s) (cracked or fractured)	☐	☐	☐	Palpitation, pounding heart or abnormal heartbeat	☐	☐	☐
Hay fever	☐	☐	☐	Frequent indigestion or heartburn	☐	☐	☐	Heart trouble or murmur	☐	☐	☐
Chronic or frequent colds	☐	☐	☐	Stomach, liver, intestinal trouble, or ulcer	☐	☐	☐	High or low blood pressure	☐	☐	☐
Severe tooth or gum trouble	☐	☐	☐	Gall bladder trouble or gallstones	☐	☐	☐	Nervous trouble of any sort (anxiety or panic attacks)	☐	☐	☐
Thyroid trouble or goiter	☐	☐	☐	Jaundice or hepatitis (liver disease)	☐	☐	☐	Habitual stammering or stuttering	☐	☐	☐
Eye disorder or trouble	☐	☐	☐	Rupture/hernia	☐	☐	☐	Loss of memory or amnesia	☐	☐	☐
Ear, nose, or throat trouble	☐	☐	☐	Rectal disease or blood from the rectum	☐	☐	☐	Frequent trouble sleeping	☐	☐	☐
Loss of vision in either eye	☐	☐	☐	Skin diseases (e.g., acne, eczema, psoriasis, etc.)	☐	☐	☐	Received mental health counseling of any type	☐	☐	☐
Worn contact lenses or glasses	☐	☐	☐	Frequent or painful urination	☐	☐	☐	Depression or excessive worry	☐	☐	☐
A hearing loss or wear a hearing aid	☐	☐	☐	High or low blood sugar	☐	☐	☐	Been evaluated or treated for a mental condition	☐	☐	☐
Surgery to correct vision (RK, PRK. LASIK, etc.)	☐	☐	☐	Kidney stone or blood, sugar, or protein in urine	☐	☐	☐	Attempted suicide	☐	☐	☐
Painful shoulder, elbow or wrist (pain, dislocation, etc.)	☐	☐	☐	Adverse reaction to serum, food, insect stings or medicine	☐	☐	☐	Used illegal drugs or abused prescription drugs	☐	☐	☐
Arthritis, rheumatism, or bursitis	☐	☐	☐	Recent unexplained gain or loss of weight	☐	☐	☐	**QUESTIONS FOR FEMALES ONLY**			
Recurrent back pain or any back problem	☐	☐	☐	Car, train, sea, or air sickness	☐	☐	☐	Treatment for Gynecological (female) Disorder	☐	☐	☐
Numbness or tingling	☐	☐	☐	Tumor, growth, cyst, or cancer	☐	☐	☐	A change of menstrual pattern	☐	☐	☐
Loss of finger or toe	☐	☐	☐	Dizziness or fainting spells	☐	☐	☐	Any abnormal PAP smears	☐	☐	☐

Check Each Item, if "Yes" Explain in Blank Space Below. List explanation by item number

Item	Yes	No
9. Have you been treated for a mental condition? If yes, specify when, where, and give details.	☐	☐
10. Have you been denied life insurance? If yes, state reason and give details.	☐	☐
11. Have you had, or have been advised to have any operation? If yes, describe.	☐	☐
12. 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?	☐	☐
13. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the year, for other than minor illness?	☐	☐
14. Do you have a past or current medical history of any other condition not mentioned on this form?	☐	☐
15. 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.	☐	☐
Explanation of all "Yes" findings		

16. 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.

16a. OFFICIAL BUREAU NAME, Typed or Printed	16b. Signature of Examinee	16c. Date

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

17. HEALTH CARE PROFESSIONAL SUMMARY AND ELABORATION OF ALL PERTINENT DATA (COMMENT ON ALL POSITIVE ANSWERS IN ITEM 6 – 15. ***Reviewer may develop any additional medical history deemed important, and record any significant findings here.***

Privacy Act Statement: The collection of the 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 eligibility 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. This information is maintained in your medical file in the FBI Central 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.

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).

18. Typed or Printed Name of Physician or Health Care Professional (HCP)	18a. Signature of Physician or HCP	18b. Date

PLEASE USE ADDITIONAL PAGES IF NECESSARY