

**DoD Medical Examination Review Board  
8034 Edgerton Drive, Suite 132  
USAF Academy, Colorado 80840-2200**

**HEAD INJURY QUESTIONNAIRE**

NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Please complete the questions below regarding history of head injury(ies) and return this form to DoDMERB at the above address: If more space is needed, please use back of form and identify each issue by question number.**

**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 Corp (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 applicants 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) How did your head injury(ies) occur? \_\_\_\_\_  
\_\_\_\_\_

2) How old were you when it/they happened? \_\_\_\_\_

3) Did you experience loss of consciousness? YES NO If yes, how long? \_\_\_\_\_

4) Did you experience amnesia? YES NO If yes, how long? \_\_\_\_\_

5) Were you treated at a hospital or by a medical provider? YES NO If yes, what type(s) of treatment and/or tests was/were accomplished? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6) Did you have any symptoms after the injury (e.g., headaches, vomiting, disorientation, double vision, dizziness, etc.)? YES NO  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7) How long did your symptoms last after your injury, if applicable? \_\_\_\_\_

8) Were any additional procedures accomplished (e.g., electroencephalogram, brain scan, burr holes, pneumoencephalogram, etc.)? YES NO If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9) Certification: By signing below, I hereby certify that the above information is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

Head Injury Questionnaire