

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

INSECT ALLERGY QUESTIONNAIRE

NAME: _____ SOCIAL SECURITY NUMBER: _____-_____-_____

Please complete all of the questions below regarding history of insect allergies 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) Have you ever been diagnosed with an insect allergy? (e.g., bee stings, fire ant bites etc.)? (circle) YES NO

If yes, please answer all the questions below:

a) Name the insect species you are allergic to: _____

b) Age at the time of diagnosis or first occurrence : _____ Age at the time of the most recent occurrence: _____

c) Were you treated for this in a hospital or emergency room? YES NO

d) Were you prescribed an Epi-Pen to carry with you? YES NO

e) Did you have any of the following symptoms when you were last stung or bitten:

Pain at the site of the bite or sting	Yes	No
Swelling or redness at the site of the bite or sting	Yes	No
Hives (urticaria)	Yes	No
Swelling away from the site of the bite or sting	Yes	No
Shortness of breath or difficulty breathing	Yes	No
Throat swelling or tightening	Yes	No
Stomach pain	Yes	No
Loss of consciousness	Yes	No
Other symptoms?	Yes	No

If **other symptoms**, please describe:

2) Have you received allergy shots (immunotherapy) for your insect allergy? YES NO

If yes, please note the dates your allergy treatments started and ended _____

3) 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

Insect Allergy Questionnaire