False statements delay the validation process because false or incomplete statements may contradict the medical history found in electronic medical documents. False statements or failure to list relative medical history, medications, or allergies may jeopardize your health and the success of the mission. Also, failure to disclose your medical history can lead to penalties for the Deployer or EE student or disqualification for the deployment.

Individuals should list any and all medications and supplements they are taking, prescription or over the counter. Listed medications and supplements must have explanation for why each is being take documented in section 30. If not, it will likely delay the validation process, as an inquiry takes place to identify the reason for the medication or supplement.

If you have sleep apnea, please identify when and where you completed your sleep study and provide us with a copy. If CPAP was recommended for you, please provide us with a CPAP compliance report that is current (completed in the last 90 days) and covers a minimum duration of 30 days.

Cell is best, we need to contact you with questions

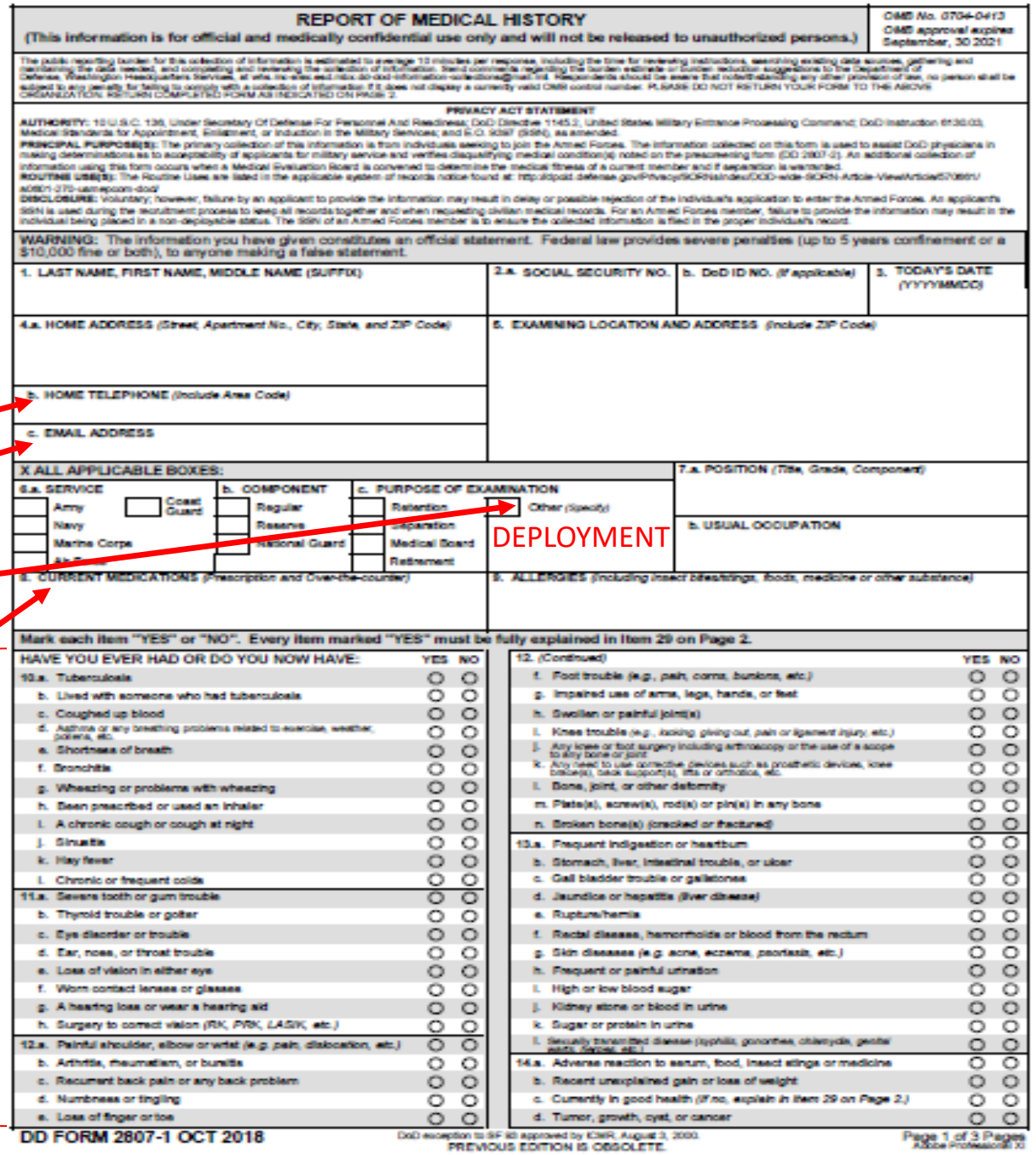
Work and personal in case you lose access to .mil

Write in DEPLOYMENT as purpose of exam

Be as accurate as possible, failure to list meds can/will cause you to be delayed or require you to submit follow up documents.

Be as accurate as possible, failure to report an issue can/will cause you to be delayed or require you to do follow up documents.

***If you are drawing a VA disability you need to list all the Issues you have reported to VA as those documents will also be reviewed. Report these upfront even if you think they are minor, the Doctor has to see them to make the call*



REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0413
OMB approval expires September, 30 2021

PRIVACY ACT STATEMENT

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)
2.a. SOCIAL SECURITY NO.
b. DoD ID NO. (If applicable)
3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)
5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)
b. HOME TELEPHONE (Include Area Code)
c. EMAIL ADDRESS

X ALL APPLICABLE BOXES:

6.a. SERVICE: Army, Coast Guard, Navy, Marine Corps
b. COMPONENT: Regular, Reserve, National Guard
c. PURPOSE OF EXAMINATION: Retention, Separation, Medical Board, Retirement, Other (Specify) DEPLOYMENT
7.a. POSITION (Title, Grade, Component)
b. USUAL OCCUPATION
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)
9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis		
b. Lived with someone who had tuberculosis		
c. Coughed up blood		
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.		
e. Shortness of breath		
f. Bronchitis		
g. Wheezing or problems with wheezing		
h. Been prescribed or used an inhaler		
i. A chronic cough or cough at night		
j. Sinusitis		
k. Hay fever		
l. Chronic or frequent colds		
11.a. Severe tooth or gum trouble		
b. Thyroid trouble or goiter		
c. Eye disorder or trouble		
d. Ear, nose, or throat trouble		
e. Loss of vision in either eye		
f. Worn contact lenses or glasses		
g. A hearing loss or wear a hearing aid		
h. Surgery to correct vision (RK, PRK, LASIK, etc.)		
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)		
b. Arthritis, rheumatism, or bursitis		
c. Recurrent back pain or any back problem		
d. Numbness or tingling		
e. Loss of finger or toe		

12. (Continued)	YES	NO
f. Foot trouble (e.g., pain, corns, bunions, etc.)		
g. Impaired use of arms, legs, hands, or feet		
h. Swollen or painful joint(s)		
i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)		
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint		
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.		
l. Bone, joint, or other deformity		
m. Plate(s), screw(s), rod(s) or pin(s) in any bone		
n. Broken bone(s) (cracked or fractured)		
13.a. Frequent indigestion or heartburn		
b. Stomach, liver, intestinal trouble, or ulcer		
c. Gall bladder trouble or gallstones		
d. Jaundice or hepatitis (liver disease)		
e. Rupture/hernia		
f. Rectal disease, hemorrhoids or blood from the rectum		
g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)		
h. Frequent or painful urination		
i. High or low blood sugar		
j. Kidney stone or blood in urine		
k. Sugar or protein in urine		
l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)		
14.a. Adverse reaction to serum, food, insect stings or medicine		
b. Recent unexplained gain or loss of weight		
c. Currently in good health (If no, explain in Item 29 on Page 2.)		
d. Tumor, growth, cyst, or cancer		

DD FORM 2807-1 OCT 2018

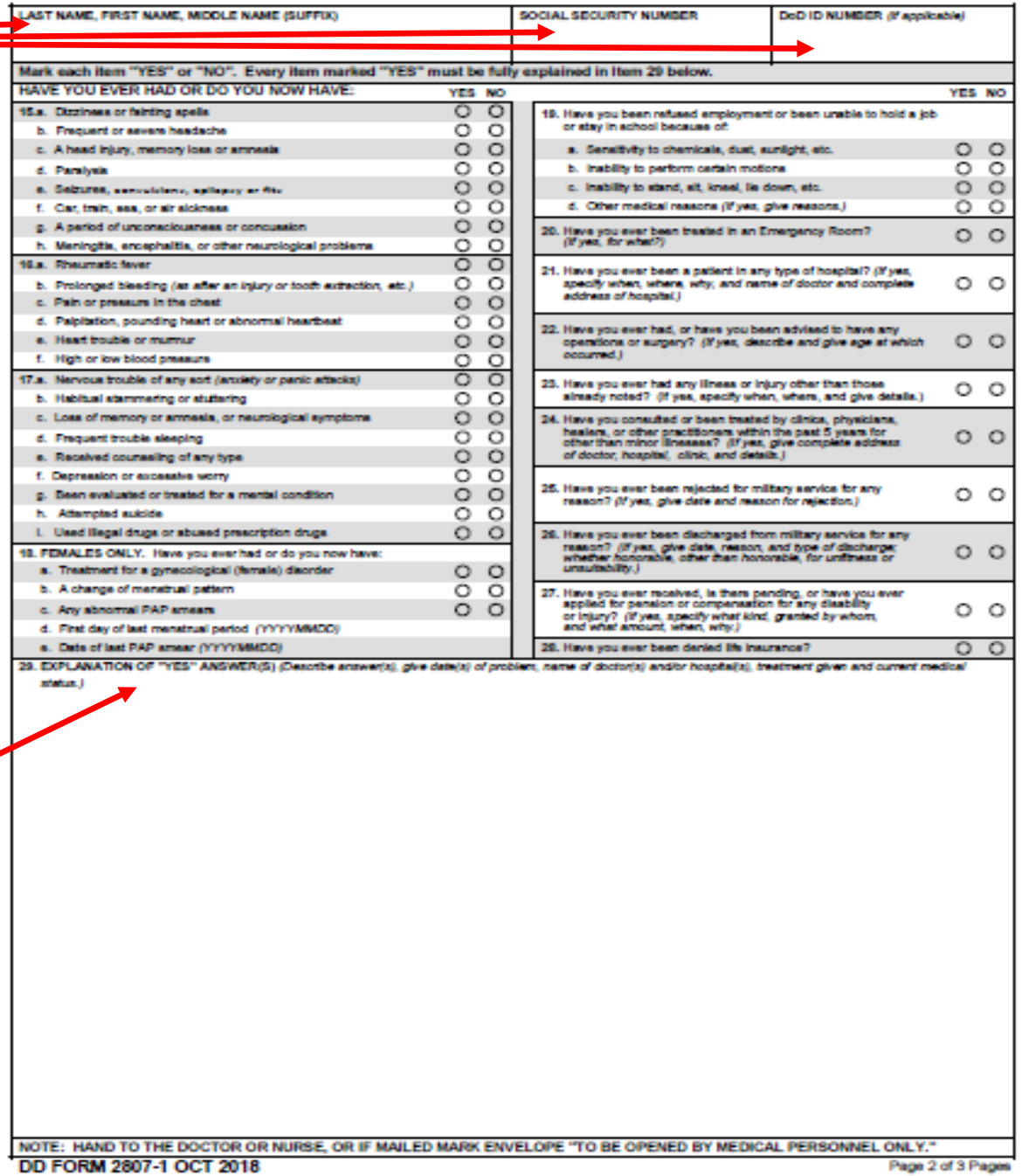
DoD exception to SF 93 approved by ICSR, August 3, 2000.
PREVIOUS EDITION IS OBSOLETE.

Page 1 of 3 Pages
Adobe Professional XI

ENSURE ADMINISTRATIVE DATA IS COMPLETE AND LEGIBLE ON PAGES OF EACH FORM

Our biggest issues with DD2807s is that the deployer does not read it and either intentionally or unintentionally, doesn't fill it out accurately. It must be stressed to deployers and Force Providers, incomplete, inaccurate and misleading DD2807s will only lead to a delay in their validation process, possibly end in a denial for deployability, and ultimately can harm them.

All "YES" responses MUST be fully explained in BOX 29.



LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | SOCIAL SECURITY NUMBER | DoD ID NUMBER (If applicable)

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
16.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
17.a. Rheumatic fever	○	○
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort (anxiety or panic attacks)	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period (YYYYMMDD)		
e. Date of last PAP smear (YYYYMMDD)		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons (If yes, give reasons.)	○	○
20. Have you ever been treated in an Emergency Room? (If yes, for what?)	○	○
21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	○	○
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	○	○
25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	○	○
26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)

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

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Page 2 of 3 Pages

Medications and supplements listed in block 8 must have explanation for why each is being take documented in section 30. If not, again, it will likely delay the validation process, as an inquiry takes place to identify the reason for the medication or supplement.

ENSURE ADMINISTRATIVE DATA IS COMPLETED ON ALL FORMS TO INCLUDE PRINTED NAMES, DATES, AND SIGNATURES