

<b>REPORT OF MEDICAL EXAMINATION</b>	1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
--------------------------------------	--------------------------------------	---------------------------

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

**PRINCIPAL PURPOSE(S):** To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

**ROUTINE USE(S):** None.

**DISCLOSURE:** Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
---	--	---

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
----------	--------------------------------	--------	--	--	--

11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY    b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE Organization: UIC code:
--	---------------------------------------	--

14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS
---	----------------------	--------------------

15.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input type="checkbox"/> Commission    Retirement <input type="checkbox"/> Retention    U.S. Service Academy <input type="checkbox"/> Separation    ROTC Scholarship Program	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
---	---	--	---

**CLINICAL EVALUATION** (Check each item in appropriate column. Enter "NE" if not evaluated.)

	Nor- mal	Ab- norm	NE	44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)
17. Head, face, neck, and scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Mouth and throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Drums (Perforation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Eyes - General (Visual acuity and refraction under items 61 - 63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Pupils (Equality and reaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Ocular motility (Associated parallel movements, nystagmus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Heart (Thrust, size, rhythm, sounds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Lungs and chest (Include breasts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29. Vascular system (Varicosities, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Abdomen and viscera (Include hernia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32. External genitalia (Genitourinary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
33. Upper extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34. Lower extremities (Except feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
35. Feet (See Item 35 Continued)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36. Spine, other musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Identifying body marks, scars, tattoos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38. Skin, lymphatics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40. Psychiatric (Specify any personality deviation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
41. Pelvic (Females only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
42. Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.) <input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable    Class _____	35. FEET (Continued) (Circle category) <input type="checkbox"/> Normal Arch <input type="checkbox"/> Mild <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Pes Cavus <input type="checkbox"/> Moderate <input type="checkbox"/> Pes Planus <input type="checkbox"/> Severe <input type="checkbox"/> Symptomatic
--	--

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)											SOCIAL SECURITY NUMBER					
<b>LABORATORY FINDINGS</b>																
45. URINALYSIS			a. Albumin			46. URINE HCG			47. H/H			48. BLOOD TYPE				
			b. Sugar													
<b>TESTS</b>			<b>RESULTS</b>						<b>HIV SPECIMEN ID LABEL</b>			<b>DRUG TEST SPECIMEN ID LABEL</b>				
49. HIV																
50. DRUGS																
51. ALCOHOL																
52. OTHER																
a. PAP SMEAR																
b.																
c.																
<b>MEASUREMENTS AND OTHER FINDINGS</b>																
53. HEIGHT		54. WEIGHT lbs.		55. MIN WGT - MAX WGT				MAX BF %				56. TEMPERATURE		57. PULSE		
58. BLOOD PRESSURE						59. RED/GREEN ( <i>Army Only</i> )						60. OTHER VISION TEST				
a. 1ST		b. 2ND		c. 3RD												
SYS.		SYS.		SYS.												
DIAS.		DIAS.		DIAS.												
61. DISTANT VISION				62. REFRACTION BY AUTOREFRACTION OR MANIFEST						63. NEAR VISION						
Right 20/		Corr. to 20/		By		S.		CX		Right 20/		Corr. to 20/		by		
Left 20/		Corr. to 20/		By		S.		CX		Left 20/		Corr. to 20/		by		
64. HETEROPHORIA ( <i>Specify distance</i> )																
ES		EX		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD		
65. ACCOMMODATION				66. COLOR VISION ( <i>Test used and result</i> )						67. DEPTH PERCEPTION ( <i>Test used and score</i> ) AFVT						
Right		Left		PIP /14						Uncorrected		Corrected				
68. FIELD OF VISION						69. NIGHT VISION ( <i>Test used and score</i> )						70. INTRAOCULAR TENSION				
												O.D.		O.S.		
71a. AUDIOMETER		Unit Serial Number						71b. Unit Serial Number						72a. READING ALOUD TEST		
Date Calibrated (YYYYMMDD)						Date Calibrated (YYYYMMDD)						<input type="checkbox"/> SAT <input type="checkbox"/> UNSAT				
HZ		500	1000	2000	3000	4000	6000	HZ		500	1000				2000	3000
Right								Right								
Left								Left								
72b. VALSALVA																
<input type="checkbox"/> SAT <input type="checkbox"/> UNSAT																
73. NOTES ( <i>Continued</i> ) AND SIGNIFICANT OR INTERVAL HISTORY ( <i>Use additional sheets if necessary.</i> )																

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
---	------------------------

<b>74.a. EXAMINEE/APPLICANT</b> ( <i>check one</i> ) <input type="checkbox"/> IS QUALIFIED FOR SERVICE <input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE	<b>75. I have been advised of my disqualifying condition.</b> a. SIGNATURE OF EXAMINEE b. DATE (YYYYMMDD)
--	---

b. PHYSICAL PROFILE														PROFILER INITIALS	DATE (YYYYMMDD)	
P	U	L	H	E	S	X										

76. SIGNIFICANT OR DISQUALIFYING DEFECTS													
ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DIS-QUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED					
								SERVICE	DATE (YYYYMMDD)				

77. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*) (*Use additional sheets if necessary.*)

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*) (*Use additional sheets if necessary.*)

79. MEPS WORKLOAD ( <i>For MEPS use only</i> )							
WKID	ST	DATE (YYYYMMDD)	INITIAL	WKID	ST	DATE (YYYYMMDD)	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN ( <i>Indicate which</i> )	b. SIGNATURE
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.		
a. SIGNATURE	b. GRADE	c. DATE (YYYYMMDD)

86. WAIVER GRANTED ( <i>If yes, date and by whom</i> )	87. NUMBER OF ATTACHED SHEETS
<input type="checkbox"/> YES <input type="checkbox"/> NO	