

REPORT OF MEDICAL EXAMINATION				1. DATE OF EXAMINATION (YYYYMMDD)		2. SOCIAL SECURITY NUMBER	
PRIVACY ACT STATEMENT							
<p>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.</p>							
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		
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 <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> 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.)							
				Normal	Ab-normal	NE	
17. Head, face, neck, and scalp							
18. Nose							
19. Sinuses							
20. Mouth and throat							
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)							
22. Drums (Perforation)							
23. Eyes - General (Visual acuity and refraction under items 61 - 63)							
24. Ophthalmoscopic							
25. Pupils (Equality and reaction)							
26. Ocular motility (Associated parallel movements, nystagmus)							
27. Heart (Thrust, size, rhythm, sounds)							
28. Lungs and chest (Include breasts)							
29. Vascular system (Varicosities, etc.)							
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)							
31. Abdomen and viscera (Include hernia)							
32. External genitalia (Genitourinary)							
33. Upper extremities							
34. Lower extremities (Except feet)							
35. Feet (See Item 35 Continued)							
36. Spine, other musculoskeletal							
37. Identifying body marks, scars, tattoos							
38. Skin, lymphatics							
39. Neurologic							
40. Psychiatric (Specify any personality deviation)							
41. Pelvic (Females only)							
42. Endocrine							
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.)				44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)			
<input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable Class _____				35. FEET (Continued) (Circle category) Normal Arch Mild Asymptomatic Pes Cavus Moderate Pes Planus Severe Symptomatic			

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)												SOCIAL SECURITY NUMBER											
LABORATORY FINDINGS																							
45. URINALYSIS				a. Albumin				46. URINE HCG				47. H/H				48. BLOOD TYPE							
				b. Sugar																			
TESTS				RESULTS				HIV SPECIMEN ID LABEL						DRUG TEST SPECIMEN ID LABEL									
49. HIV																							
50. DRUGS																							
51. ALCOHOL																							
52. OTHER																							
a. PAP SMEAR																							
b.																							
c.																							
MEASUREMENTS AND OTHER FINDINGS																							
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 ^o			EX ^o			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)														
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	SAT	UNSAT								
Right									Right						72b. VALSALVA								
Left									Left						SAT	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		
74. a. EXAMINEE/APPLICANT (check one)					75. I have been advised of my disqualifying condition.				
<input type="checkbox"/> IS QUALIFIED FOR SERVICE					a. SIGNATURE OF EXAMINEE			b. DATE (YYYYMMDD)	
<input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE									
b. PHYSICAL PROFILE									
P	U	L	H	E	S	X	PROFILER INITIALS	DATE (YYYYMMDD)	
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 (For MEPS use only)									
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 (Indicate which)					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 (if yes, date and by whom)								87. NUMBER OF ATTACHED SHEETS	
<input type="checkbox"/> YES									
<input type="checkbox"/> NO									