REPORT OF MEDICAL EXAMINATION

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	10.a. RACIAL CATEGORY *(X one or more)*			b. ETHNIC CATEGORY
			☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Asian	☐ Black or African American ☐ White	☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic/Latino ☐ 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	b. COMPONENT	c. PURPOSE OF EXAMINATION		16. NAME OF EXAMINING LOCATION, AND ADDRESS *(Include ZIP Code)*
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Diving ☐ NSW / SO ☐ Commission ☐ Retention	☐ Nuclear Field Duty ☐ Submarine Duty ☐ HAPS (HALO) ☐ Other	

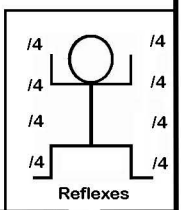
CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	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 Skin Cancer Screen			
39. Neurologic (Diver Neuro Exam needed for NSW, Diving, HAPS)			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

#22. Valsalva POS BILAT - Yes No

#39. Diver Neuro Exam
CN II - XII: Intact - Yes No Symmetric - Yes No
Sensory Intact to Pin Prick/Light Touch - Yes No
Rapid Alternating Movements - Normal Abnormal
Heel to Shin - Normal Abnormal
Finger to Nose - Normal Abnormal
Gait - Normal Abnormal
Romberg - Negative (Normal) Positive (Abnormal)
Motor/Strength 5/5 Throughout - Yes No



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.)*
☐ Acceptable
☐ 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
_____ RBC/HPF	b. Sugar			

TESTS	RESULTS	CXR	WBC	DRUG TEST SPECIMEN ID LABEL
49. HIV				SICKLE CELL NEG POS
50. PPD			PLT	G6PD NL ABNL
51. HEP C				CHOL
52. OTHER		EKG	PSA	TG
a. PAP SMEAR				HDL
b. FBS				LDL
c. STOOL GUIAC				

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 *(Army Only)*	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 *(Specify distance)*

ES° EX° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP /14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER Unit Serial Number

Date Calibrated *(YYYYMMDD)*

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

71b. Unit Serial Number

Date Calibrated *(YYYYMMDD)*

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

72a. READING ALOUD TEST ☐ SAT ☐ UNSAT

72b. VALSALVA ☐ SAT ☐ UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

Immunizations up to date (MUST HAVE 2 DOSES of HEP A and HEP B DOCUMENTED IN SHOT RECORD BEFORE MEMBER CAN BEGIN DIVE TRAINING).

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

74.a. EXAMINEE/APPLICANT *(check one)*

- [ ] IS QUALIFIED FOR SERVICE
- [ ] IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

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)*	QUALI-FIED	DIS-QUALI-FIED	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)*

- [ ] YES
- [ ] NO

87. NUMBER OF ATTACHED SHEETS