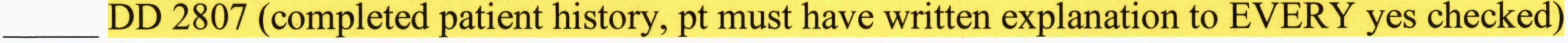
BMC-MAINSIDE-BLDG 15

Physical Exam Dept

Pre- Commissioning

Please check each section after paperwork is completed and reviewed:



ALL SECTIONS MUST BE COMPLETED PRIOR TO BEING SEEN BY PROVIDER

PHA (within one year) (Date):

Audiogram (Annual for all USMC) (Date):

ental Exam **MUST** be Class I or II (with signatures) (Exam Date):

Pap Exam (within three years) (Date):

Labs:

HIV within one year) Date:

Lipids (within 90 days) Date: FBS (within 90 days) Date: UA (within 90 days) Date: CBC (within 90 days) Date:

D 2808 (Ensure all eye, hearing, and lab results are recorded rior to a2 ointment) EKG

Additional Notes

**REPORT OF MEDICAL HISTORY**

*0MB No. 0704-0413*

I*0MB approval expires*

## (This information is for official and medically confidential use only and will not be released to unauthorized persons.) *20241031*

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reaction suggestions to the Department of Defense, Washington Headquarter Services, at [whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil.](mailto:whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil) Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid DMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. 136, Under Secretary of Defense For Personnel and Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.

**PRINCIPAL PURPOSE($):** The primary collection of this informatioo is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted oo the prescreening from (DD 2807-2)/. An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted.

**ROUTINE USE(S):** The Routine Uses are listed in the applicable system of records notice found at: <http://dpcld.defense.gov/Privacy/S0RNslndex/DOD-wide-S0RN-Article-View/Article/570661/a0601-270-> usmepcom-dod/

**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. An applicant's SSN is used during the recruitment process to keep all records together and 'Nhen requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

**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.

# LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) --

1. **a SOCIAL SECURITY NO. b. DoD ID NO.** *(If applicable)* **3. TODAY'S DATE**

*(YYYYMMDD)*

**4.a. HOME ADDRESS** *(Stress, Apartment No., City,* State, *and ZIP Code)* **5. EXAMINING LOCATION AND ADDRESS** *(Include Zip Code)*

Mainside Medical

Building 15 Holcomb Blvd Camp Lejeune 28542

**b. HOME TELEPHONE** *(Include Area Code)*

**c. EMAIL ADDRESS**

-

# X ALL APPLICABLE BOXES:

## 6.a. SERVICE

Navy Guard

-

## b. COMPONENT

§

Reserve

Separation

**b. USUAL OCCUPATION**

## c. PURPOSE OF EXAMINATION

**7.a. POSITION** *(Title, Grade, Component)*

- - Army

Marine Corps National Guard Medical Board

Air Force

-

□ Coast

Regular - Retention D Other *(Specify)*

Retirement

**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 0 0

1. Lived with someone who had tuberculosis 0 0
2. Coughed up blood 0 0
3. Asthma or any breathing problems related to exercise, weather, pollens, O

0

etc.

1. Shortness of breath 0 0

f. Bronchitis 0 0

1. Wheezing or problems with wheezing 0 0
2. Been prescribed or used an inhaler 0 0
3. **A** chronic cough or cough at night 0 0
4. Sinusitis 0 0
5. Hay fever 0 0

I. Chronic or frequent colds 00

11.a. Severe tooth or gum trouble 0 0

1. Thyroid trouble or goiter 0 0
2. Eye disorder or trouble 0 0
3. Ear, nose, or throat trouble 0 0
4. Loss or vision in either eye 0 0
5. Worn contact lenses or glasses 0 0
6. A hearing loss or **wear** a hearing aid 0 0
7. Surgery to correct vision *(RK, PRK, LASIK, etc.)* 0 0

12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)* 0 0

1. Arthritis, rheumatism, or bursitis 0 0
2. Recurrent back pain or any back problem 0 0
3. Numbness or tingling 0 0
4. Loss of finger or toe 0 0

**12.** *(Continued}* **YES NO**

1. Foot trouble *(e.g., pain, corns, bunions, etc.)* 0 0
2. Impaired use of arms, legs, hands, or feet) 0 0
3. Swollen or painful joint(s) 0 0
4. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)* 0 0
5. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint 0 0
6. Any need to use corrective devices such as prosthetic devices, knee brace(s), back

0 0

support(s), lifts, or orthotics, etc.

I. Bone, joint, or other deformity 0 0

1. Plate(s), screw(s), rod(s), or pin(s) in any bone 0 0
2. Broken bone(s) *(cracked of fractured)* 0 0

**13.a.** Frequent indigestion or heartburn 0 0

1. Stomach, liver, intestinal trouble, or ulcer 0 0
2. Gall bladder trouble or gallstones 0 0
3. Jaundice or hepatitis *(liver disease)* 0 0
4. Rupture/hernia 0 0
5. Rectal disease, hemorrhoids, or blood from the rectum 0 0
6. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)* 0 0
7. Frequent or painful urination 0 0
8. High or low blood sugar 0 0
9. Kidney stone or blood in urine 0 0
10. Sugar or protein in urine 0 0

I. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)* Q 0

14.a. Adverse reaction to serum, food, insect stings, or medicine 0 0

1. Recent unexplained gain or loss of weight 0 0
2. Currently in good health *(If no, explain in Item 29 on Page 2.)* 0 0
3. Tumor, growth, cyst, or cancer 0 0

**DD FORM 2807-1, OCT 2018**

**CUI (when filled in)**

PREVIOUS EDITION IS OBSOLETE.

Controlled by: OUSD(P&R) CUI Category: PRVCY, HLTH LDC: FEDCON

## Page 1 of 3

POC: [osd.pentagon.ousd-p-r.mbx.forms@mail.mil](mailto:osd.pentagon.ousd-p-r.mbx.forms@mail.mil)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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** |  | |  | | **YES NO** |
| 15.a. Dizziness or fainting spells   1. Frequent or severe headache 2. A head injury, memory loss or amnesia 3. Paralysis 4. Seizures, convulsions.epilepsy, or fits 5. Car, train,sea,or air sickness 6. A period of unconsciousness or concussion 7. Meningitis, encephalitis, or other neurological problems | 0 0  0 0  0 0  0 0  0 0  0 0  0on0 |  | | 1. Have you been refused employment, or been unable to hold a job or stay in school because of:    1. Sensitivity to chemicals, dust, sunlight, etc.    2. Inability to perform certain motions    3. Inability to stand, sit, kneel, lie down, etc.    4. Other medical reasons *(If* yes, *give reasons.)* | | 0 0  0 0  0 0  0 0 |
| 20. Have you ever been treated in an Emergency Room? *{If* yes, *for what?)* | | 0 0 |
| 16.a. Rheumatic fever   1. Prolonged bleeding *(as after an injury or tooth extraction, etc.)* 2. Pain or pressure in the chest 3. Palpitation, pounding heart or abnormal heartbeat 4. Heart trouble or murmur 5. High or low blood pressure | 0 0  0 0  0 0  0 0  0on0 |
| 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.* | | 0 0 |
| 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.}* | | 0 0 |
| 17.a. Nervous trouble of any sort *(anxiety or panic attacks)*   1. Habitual stammering or stuttering 2. Loss of memory or amnesia, or neurological symptoms 3. Frequent trouble sleeping 4. Received counseling of any type 5. Depression or excessive worry 6. Been evaluated or treated for a mental condition 7. Attempted suicide 8. Used illegal drugs or abused prescription drugs | 0 0  0 0  0 0  0 0  0 0  0 0  0 0  0 0  0 0 | 23. Have you ever had any illness or injury other than those already noted?  *(If yes, specify when, where, and give details.)* | | 0 0 |
| 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.)* | | 0 0 |
| 25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)* | | 0 0 |
| 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.)* | | 0 0 |
| 1. **FEMALES ONLY.** Have you ever had or do you now have:    1. Treatment for a gynecological (female) disorder    2. A change of menstrual pattern    3. Any abnormal PAP smears    4. First day of last menstrual period *(YYYYMMDD)*    5. Date of last PAP smear *(YYYYMMDD)* | 0 0  0 0  0 0  0 0 |
| 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.)* | | 0 0 |
| 28. Have you ever been denied life insurance? | | 0 0 |
| **29. EXPLANATION OF "YES" ANSWER($)** *(Describe answer(s), give date(s) of problem, name of doctor(s)andlor* **hospital(s),** *treatment given and current medical status.)* | | | | | | |
| **NOTE: HAND TO THE DOCTOR OR NUSE, OR IF MAILED MARK ENVELOPE ''TO BE OPENED BY MEDICAL PERSONNEL ONLY.'** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| LAST **NAME,** FIRST **NAME,** MIDDLE **NAME** (SUFFIX) | | SOCIAL SECURITY NUMBER  n/a | | | DoD ID NUMBER *(If applicable)* | |
| **:'E MINER'S-SUMM:ARrAND-El:ABORATION-orAl:l:'PERTINENrD:AT** | | | *(Physician/practitioner shall comment on all positive answers in questions* | | | |
| *10- 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)* | | | | | | |
| I**J;'COMMENTI** | | | | | | |
| **l):'TYPED-OR-PRINTED :AME-oF-E MINER!***(Last, First, Middle Initial)* | I **c."SlGN:ATURE** | | | **\** | | **dro:ATE-SIGNEDl**  *(YYYYMMDD)* |
|  | | | | |

**0**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. DATE OF EXAMINATION** 2NirlAL SECURITY NUMBER **2b. DoD** ID **NUMBER**  **REPORT OF MEDICAL EXAMINATION** *(YYYYMMDD) (If applicable)*  **1** 1 **1** | | | | | | | | | | | | | | | | | | | | | | |
| **PRIVACY ACT STATEMENT**  **AUTHORITY:** 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, **Regular components: qualifications, term, grade;** 10 U.S.C. 507, **Extension of enlistment for members needing medical care or hospitalization;** 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency: testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, Unned States Military Entrance Processing Command; E.O. 9397 (SSN) and 10 U.S.C. 1204, Members on Active Duty for 30 Days or Less or on Inactive Duty Training: Retirement, as amended.  **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):** The Routine Uses are listed in the applicable system of records notice found at: <http://dpcld.defense.gov/Privacy/SORNslndex/DOD-wide-SORN-Articie-View/> Articie/570661/a0601-270-usmepcom-dod/  **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)* | | | | | | | | | | | | | **Sa. HOME TELEPHONE**  **NUMBER** *(Include Area Code)* | | **Sb. E-MAIL ADDRESS** | |
| **6.GRADE/ RANK** | 7, **DATE** OF **BIRTH**  *(YYYYMMDD)* | | **8.AGE** | **9a. BIRTH SEX**  0Male  □Female | | | | **9b. PREFERRED GENDER**  0Male  0Female | | | | | **10a. ETHNIC CATEGORY**  D Hispanic/Latino  D Non Hispanic/Latino | | | | | | | □**10b. RACIAL CATEGORY** *(Select one)*  American Indian or Alaska Native 0Asian  OBlack or African American DWhne 0Native Hawaiian or Other Pacific Islander | | |
| **11. TOTAL YEARS GOVERNMENT SERVICE** | | | | **12. AGENCY** *(Non-Service Members Only)* | | | | | | | | | | | | | | | **13. ORGANIZATION UNIT AND UICICODE** | | | |
| **a. MILITARY** | I**b. CIVILIAN** | |  |
| **14a. RATING OR SPECIALTY** *(Aviators Only)* | | | | |  |  | **I14b. TOTAL FLYING TIME** | | | | |  |  |  |  |  |  | **I14c. LAST SIX MONTHS** | | | |  |
| **15a. SERVICE**  □Army  0AirForce  □0Marine Corps Navy  ncoast Guard | | **15b. COMPONENT**  □0Active Duty Reserve  D National Guard | | | □**15c. PURPOSE OF EXAMINA**□**TION**  Enlistment Retirement  Ocommission Ou.s. Service Academy  0Retention D ROTC Scholarship Program  Oseparation D Medical Board  Oother | | | | | | | | | | | | | **16. NAME OF EXAMINING LOCATION, AND ADDRESS**  *(Include Zip Code)*  Mainside Medical Building 15 Holcomb Blvd  Camp Lejeune, NC 28542 | | | |  |
| **MEDICAL EVALUATION** *(Check each item in appropriate column. Enter "NE" if not evaluated.)* | | | | | | | | | | | | | | | | | | **43-:-QENTAL"DEFECTs--ANO-DlSE;ll; E** Acceptable  *(Please explain. Use dental form if*  *completed by dentist. If abnormality noted,* Not Acceptable D  *explain in item 44.)*  Class | | | | |
|  | | | | | | | | | **Nonnal** | | | **Abnormal** | | | **NE** | | |
| **17.** Head, face, neck and scalp | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **18.** Nose | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **19.** Sinuses | | | | | | | | |  |  |  |  |  |  |  |  |  | **44. NOTES:** *(Mandatory comment for every abnormality identified in items 17* - *43. Enter pertinent item number before each comment. Continue comments or use drawings in item 89 and use additional sheets if necessary.)* | | | | |
| **20.** Mouth and throat | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **21.** Ears - General *(Int. and ext. canals/Auditory acuity under item 71)* | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **22.** Tympanic Membranes *(Perforation)* | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **23.** Eyes - General | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **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 *(Check category)* | | | | | | | | |  |  |  |  |  |  |  |  |  |
| 35a. D Normal Arch D Pes Planus D Pes Cavus | | | | | | | | |  | | | | | | | | |
| 35b. | Mild D | | Moderate | |  | □D | Severe | |
| 35c. D | Asymptomatic D | | Symptomatic | | |  | Rigid | |
| **36.** Spine, other musculoskeletal | | | | | | | | |  |  |  |  |  |  |  | | |
| 37. Body marks, scars, tattoos | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **38.** Skin, lymphatics | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **39.** Neurologic | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **40.** Psychiatric *(Specify any personality disorder)* | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **41.** Pelvic *(Females only)* | | | | | | | | |  |  |  |  |  |  |  |  |  |
| **42.** Endocrine | | | | | | | | |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| LAST NAME • FIRST NAME • MIDDLE NAME (Suffix) | | | | | | | | | | | | | | | | | SOCIAL SECURITY NUMBER  N/A | | | | | | | DoD ID NUMBER | | | | | |
| LABORATORY FINDINGS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 45. URINALYSIS | | | | | a. | Albumin | | lb. Sugar  N/A | | | | | | | | | 46. URINE HCG | | | | 147. | | H/H |  |  | 148. BLOOD TYPE | | | |
| TESTS | | | | | RESULTS | | | | | | | | | | | | HIV SPECIMEN ID | | | | LABEL | |  | DRUG TEST SPECIMEN ID LABEL | | | | | |
| 49.HIV | | | | |  | | | | | | | | | | | |
| 50. DRUGS | | | | | N/A | | | | | | | | | | | |
| 61. ALCOHOL | | | | | N/A | | | | | | | | | | | |
| 52.OTHER | | | | | N/A | | | | | | | | | | | |
| a. PAP SMEAR | | | | |  | | | | | | | | | | | |
| b.EKG | | | | |  | | | | | | | | | | | |
| c.CXR | | | | | N/A | | | | | | | | | | | |
| MEASUREMENTS AND OTHER FINDINGS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 53. HEIGHT *(in.)* | | | 54. WEIGHT *(lbs.)* | | | | | | | **55a. MINWGT** | | | **55b.MAXWGT** | | | | **55c. MAX BF%** | | | | **55d. BMI** | | | **56. TEMPERATURE** | | | **57. HEART** RATE | | |
| **58. BLOOD PRESSURE** | | | | | | | | | | | | | | | | | | 59. RED/GREEN | | | | | | | 60. OTHER **VISION** TEST | | | | |
| **a.1ST** | | | | | | b. 2ND | | | | | | c.3RD | | | | | |
| SYS. | | | | | | SYS. | | | | | | SYS. | | | | | |
| DIAS. | | | | | | DIAS. | | | | | | DIAS. | | | | | |
| **61. DISTANCE VISION** | | | | | | | | | | **62. REFRACTION AUTO** | | | | | | **MANIFEST** CYCLO | | | | |  | **63. NEAR VISION** | | | | | | | |
| Right Uncorr. 20/ | | | Corr. to 20/ | | | | | | | Sph: | | | Cyl: | | | | | | Axis: | | | Right Uncorr. 20/ | | | Corr. to 20/ | | | Add: | |
| Left Uncorr. 20/ | | | Corr. to 20/ | | | | | | | Sph: | | | Cyl: | | | | | | Axis: | | | Left Uncorr. 20/ | | | Corr. to 20/ | | | Add: | |
| **64. HETEROPHORIA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ES |  | IEx | |  |  |  |  | | R.H. I L.H. | | | | | | | Prism  Idiv. | | | | Prism ConvCT | | | INPR |  |  | IPD | | |  |
| **65. ACCOMMODATION** | | | | | | | | | **66. COLOR VISION** *(Pass/Fail and Score)* | | | | | | | | | | | | | **67. DEPTH PERCEPTION** *(Pass/Fail and Score)* | | | | | | | |
| Right |  | ILeft | |  |  |  |  | | PIP | | | | RED/ GREEN | | | Color  I Ox | | | | |  | AFVT |  |  |  | RANDOT/  I MCST | | |  |
| **68. FIELD OF VISION** | | | | | | | | | | | | **69. NIGHT VISION** | | | | | | | | | | | **70. INTRAOCULAR PRESSURE** | | | | | | |
| 0.0. |  |  | 10.s. | | |  |
| **71a. AUDIOMETER** | | Unit Serial | | | | Number | |  | | | | **71b.** Unit Serial Number | | | | | | | | | | | **72a. READING ALOUD TEST:** | | | □ SAT | | | □ UNSAT |
| Date Calibrated *(YYYYMMDD)* | | | | | | | | | | | | Date Calibrated *(YYYYMMDD)* | | | | | | | | | | | **72b. VALSALVA:** | | | SAT | | | UNSAT |
| HZ | 500 | 1000 | | 2000 | | | 3000 | | | 4000 | 6000 | HZ | | 500 | 1000 | | 2000 | | 3000 | 4000 | | 6000 | **72c. OTHER TESTING** | | | | | | |
| Left |  |  | |  | | |  | | |  |  | Left | |  |  | |  | |  |  | |  |
| Right |  |  | |  | | |  | | |  |  | Right | |  |  | |  | |  |  | |  |
| **73. NOTES AND/OR INTERVAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| LAST **NAME** • FIRST **NAME** • MIDDLE **NAME** (Suffix) | | | | | | | | | | | | | | | | SOCIAL SECURITY NUMBER  N/A | | | | | | | | DoD ID **NUMBER** | | |
| 74. EX□AMINEE  □ IS MEDICALLY QUALIFIED  IS NOT MEDICALLY QUALIFIED | | | | | | | | | | | | | | | | 75. I have been advised of my disqualifying condition(s). | | | | | | | | | | |
| 75a. SIGNATURE OF EXAMINEE | | | | | | | | 75b. DATE *(YYYYMMDD)* | | |
| 76. PHYSICAL PROFILE | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 77. SIGNIFICANT OR DISQUALIFYING MEDICAL DIAGNOSES | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ITEM NO. | MEDICAL DIAGNOSIS | | | | | | | ICD CODE | | PROFILE SERIAL RBJ DATE  *(YYYYMMDD)* | | | | | | | QUALIFIED | | DISQUALIFIED | | | EXAMINER INITIALS | | | WAIVER RECEIVED | |
| SERVICE | DATE *(YYYYMMDD)* |
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| 78. SUMMARY OF MEDICAL DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary).* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 79. RECOMMENDATIONS *(Specify) (Use additional sheets if necessary).* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 80. MEPS WORKLOAD *(For MEPS use only)* | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 81. MEDICAL INSPECTION DATE | | | | | | HT | | | WT | | %BF | | MAX WT | | HCG | | | QUAL | | DISQ | | | EXAMINER'S NAME AND SIGNATURE | | | |
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| 83a. TYPED OR PRINTED **NAME** OF PHYSICIAN OR EXAMINER | | | | | | | | | | | | | | | | 83b. Signature | | | | | | | | | | |
| **!!!a-:'TYPED OR-PRINTED NA:McOF-DENTIST** ORi"l1¥ill IIN *(Indicate which)* | | | | | | | | | | | | | |  | | **:8467'.Sjgnaool** | | | | | | | | | | |
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| 85a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY  *(Indicate which)* | | | | | | | | | | | | | | | | 85b. Signature | | | | | | | | | | |
| 86. This examination has been administratively reviewed for completeness and accuracy. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. SIGNATURE lb.GRADE | | | | | | | | | | | | | | | | |  | |  |  |  | | le. DATE *(YYYYMMDD)* | | |  |
| 87. WAIVER GRANTED *(If yes, date and by whom)*  YES | | | | | | | | | | | | | | | | | □I | |  | NO |  | | 88. NUMBER OF ATTACHED SHEETS  1 | | |  |

**89. ADDITIONAL REMARKS**