

REPORT OF MEDICAL EXAMINATION	1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
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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)
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6. GRADE CIVILIAN	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
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11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
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14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS
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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)
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CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)

	Nor- mal	Ab- norm	NE		
17. Head, face, neck, and scalp				44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)	
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 abnormality noted, explain in Item 44.)					35. FEET (Continued) (Circle category)
<input type="checkbox"/> Acceptable					N - Normal Arch 1 - Mild A - Asymptomatic
<input type="checkbox"/> Not Acceptable Class _____					C - Pes Cavus 2 - Moderate S - Symptomatic
					P - Pes Planus 3 - Severe



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				FIRST SPECIMEN ID LABEL				SECOND SPECIMEN ID LABEL						
			FIRST TEST		CODE	SECOND TEST									CODE		
49. HIV																	
50. DRUGS																	
51. ALCOHOL																	
52. OTHER																	
a. PAP SMEAR																	
b. EKG																	
c. CXR																	
MEASUREMENTS AND OTHER FINDINGS																	
53. HEIGHT		54. WEIGHT		55.a. MIN WGT - MAX WGT			55.b. ACTUAL BF % - MAX BF %			56. TEMPERATURE			57. PULSE				
		lbs.															
58. BLOOD PRESSURE						59. RED/GREEN (Army Only)				60. OTHER VISION TEST:							
a. 1ST		b. 2ND		c. 3RD						a. COLOR HAIR				b. COLOR EYES			
SYS.		SYS.		SYS.						Right:							
DIAS.		DIAS.		DIAS.						Left:							
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		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						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 (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)																	



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74.a. EXAMINEE/APPLICANT <i>(check one)</i>	75. I have been advised of my disqualifying condition. I have been advised to see my private medical care provider within 24-48-72 hours/30 days / Routine Follow-up (circle one) for further evaluation and/or treatment.
<input type="checkbox"/> IS QUALIFIED FOR SERVICE IN SPF	a. SIGNATURE OF EXAMINEE
<input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE	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)	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	



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88. Additional Remarks (extension of blocks 77 or 78).

