

## REPORT OF MEDICAL HISTORY

*Form Approved  
OMB No. 0704-0413  
Expires Aug 31, 2003*

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

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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. 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 OMB control number.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.**

### 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.

**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. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

<b>X ALL APPLICABLE BOXES:</b>			7.a. POSITION (Title, Grade, Component)
<b>6.a. SERVICE</b> <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<b>6.b. COMPONENT</b> <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<b>6.c. PURPOSE OF EXAMINATION</b> <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <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	b. USUAL OCCUPATION

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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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	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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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	<input type="radio"/>	<input type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:	<input type="radio"/>	<input type="radio"/>	
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>		c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons <i>(If yes, give reasons.)</i>	<input type="radio"/>	<input type="radio"/>
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? <i>(If yes, for what?)</i>	<input type="radio"/>	<input type="radio"/>
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>			21. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i>	<input type="radio"/>
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		22. Have you ever had, or have you been advised to have any operations or surgery? <i>(If yes, describe and give age at which occurred.)</i>	<input type="radio"/>	<input type="radio"/>
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	23. Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i>	<input type="radio"/>	<input type="radio"/>	
b. Prolonged bleeding <i>(as after an injury or tooth extraction, etc.)</i>	<input type="radio"/>	<input type="radio"/>		24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i>	<input type="radio"/>	<input type="radio"/>
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	25. Have you ever been rejected for military service for any reason? <i>(If yes, give date and reason for rejection.)</i>	<input type="radio"/>	<input type="radio"/>	
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>		26. Have you ever been discharged from military service for any reason? <i>(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)</i>	<input type="radio"/>	<input type="radio"/>
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>	27. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability or injury? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i>	<input type="radio"/>	<input type="radio"/>	
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>		28. Have you ever been denied life insurance?	<input type="radio"/>	<input type="radio"/>
17.a. Nervous trouble of any sort <i>(anxiety or panic attacks)</i>	<input type="radio"/>	<input type="radio"/>	29. EXPLANATION OF "YES" ANSWER(S) <i>(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)</i>			
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>				
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>				
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>				
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>				
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>				
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>				
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>				
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>				
18. FEMALES ONLY. Have you ever had or do you now have:						
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>				
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>				
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>				
d. First day of last menstrual period <i>(YYYYMMDD)</i>						
e. Date of last PAP smear <i>(YYYYMMDD)</i>						

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

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NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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**30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA** *(Physician shall comment on all positive answers in questions 10 - 29. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS



b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*

c. SIGNATURE

d. DATE SIGNED  
*(YYYYMMDD)*

<b>REPORT OF MEDICAL EXAMINATION</b>	1. DATE OF EXAMINATION <i>(YYYYMMDD)</i>	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.  
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6. GRADE	7. DATE OF BIRTH <i>(YYYYMMDD)</i>	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10. RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White
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11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY      b. CIVILIAN	12. AGENCY <i>(Non-Service Members Only)</i>	13. ORGANIZATION UNIT AND UIC/CODE
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14.a. RATING OR SPECIALTY <i>(Aviators Only)</i>	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 <i>(Include ZIP Code)</i>
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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				42. NOTES: <i>(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)</i>
18. Nose				
19. Sinuses				
20. Mouth and throat				
21. Ears - General <i>(Int. and ext. canals/Auditory acuity under item 72)</i>				
22. Drum <i>(Perforation)</i>				
23. Eyes - General <i>(Visual acuity and refraction under items 62 - 71)</i>				
24. Ophthalmoscopic				
25. Pupils <i>(Equality and reaction)</i>				
26. Ocular motility <i>(Associated parallel movements, nystagmus)</i>				
27. Heart <i>(Thrust, size, rhythm, sounds)</i>				
28. Lungs and chest <i>(Include breasts)</i>				
29. Vascular system <i>(Varicosities, etc.)</i>				
30. Anus and rectum <i>(Hemorrhoids, Fistulae) (Prostate if indicated)</i>				
31. Abdomen and viscera <i>(Include hernia)</i>				
32. External genitalia <i>(Genitourinary)</i>				
33. Upper extremities				
34. Lower extremities <i>(Except feet)</i>				
35. Feet				
36. Spine, other musculoskeletal				
37. Identifying body marks, scars, tattoos				
38. Skin, lymphatics				
39. Neurologic				
40. Psychiatric <i>(Specify any personality deviation)</i>				
41. Pelvic <i>(Females only)</i>				

43. DENTAL DEFECTS AND DISEASE <i>(Please explain. Use dental form if completed by dentist.)</i> <input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable    Class _____ <i>(Dental examination not done by dental officer)</i>	44. FEET <i>(Circle category)</i> <table style="width:100%;"> <tr> <td>Normal Arch</td> <td>Mild</td> <td>Asymptomatic</td> </tr> <tr> <td>Pes Cavus</td> <td>Moderate</td> <td></td> </tr> <tr> <td>Pes Planus</td> <td>Severe</td> <td>Symptomatic</td> </tr> </table>	Normal Arch	Mild	Asymptomatic	Pes Cavus	Moderate		Pes Planus	Severe	Symptomatic
Normal Arch	Mild	Asymptomatic								
Pes Cavus	Moderate									
Pes Planus	Severe	Symptomatic								

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<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 (Pre-commissioning)				
51. ALCOHOL (Only)				
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 (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	by	Right 20/	Corr. to 20/	by						
Left 20/	Corr. to 20/		By	S.	CX	by	Left 20/	Corr. to 20/	by						
64. HETEROPHORIA (Specify distance)															
ES <sup>o</sup>	EX <sup>o</sup>	R.H.	L.H.	Prism div.	Prism Conv CT (Initial Only)	NP C (Initial Only)	PD								
65. ACCOMMODATION			66. COLOR VISION (Test used and result)				67. DEPTH PERCEPTION (Test used and score) AFVT								
Right	Left						Uncorrected	Corrected							
68. FIELD OF VISION				69. NIGHT VISION (Test used and score)				70. INTRAOCULAR TENSION (Initial & 40 and above)							
								O.D.	O.S.						
71a. AUDIOMETER		Unit Serial Number					71b. Unit Serial Number					72a. READING ALOUD TEST (Initial Only)			
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 (Initial Only)	
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.	
<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 <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	