

REPORT OF MEDICAL EXAMINATION			1. DATE OF EXAMINATION (YYYYMMDD) Mandatory Field		2a. SOCIAL SECURITY NUMBER Mandatory Field		2b. DoD ID NUMBER (If applicable) Mandatory Field													
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, United 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://dpcl.d.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-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. 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) Mandatory Field			4. HOME ADDRESS (Street, Apartment Number, City, State and Zip Code) Mandatory Field			5a. HOME TELEPHONE NUMBER (Include Area Code) Mandatory Field		5b. E-MAIL ADDRESS Mandatory Field												
6. GRADE/RANK Mandatory Field	7. DATE OF BIRTH (YYYYMMDD) Mandatory Field	8. AGE Mandatory Field	9a. BIRTH SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	9b. PREFERRED GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	10a. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino		10b. RACIAL CATEGORY (Select one) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White													
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN		12. AGENCY (Non-Service Members Only)			13. ORGANIZATION UNIT AND UIC/CODE															
14a. RATING OR SPECIALTY (Aviators Only)			14b. TOTAL FLYING TIME			14c. LAST SIX MONTHS														
15a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard		15b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard Mandatory Field	15c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Other <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program <input type="checkbox"/> Medical Board Mandatory Field			16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code) Mandatory Field														
MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.) Mandatory Field					43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.) Acceptable <input type="checkbox"/> Not Acceptable <input type="checkbox"/> Class _____ Mandatory Field															
					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.)															
17. Head, face, neck and scalp									Normal				Abnormal				NE			
18. Nose																				
19. Sinuses																				
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. <input type="checkbox"/> Normal Arch <input type="checkbox"/> Pes Planus <input type="checkbox"/> Pes Cavus																				
35b. <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe																				
35c. <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> 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																				

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix) Mandatory Field						SOCIAL SECURITY NUMBER Mandatory Field						DoD ID NUMBER Mandatory Field																					
LABORATORY FINDINGS																																	
45. URINALYSIS			a. Albumin			b. Sugar			46. URINE HCG			47. H/H N/A			48. BLOOD TYPE N/A																		
TESTS			RESULTS			HIV SPECIMEN ID LABEL						DRUG TEST SPECIMEN ID LABEL N/A																					
49. HIV																																	
50. DRUGS																																	
51. ALCOHOL																																	
52. OTHER			Hep C Optional / If sm declines Hep C provider must notate																														
a. PAP SMEAR																																	
b. EKG																																	
c. CXR																																	
MEASUREMENTS AND OTHER FINDINGS																																	
53. HEIGHT (in.) Mandatory Field			54. WEIGHT (lbs.) Mandatory Field			55a. MIN WGT			55b. MAX WGT			55c. MAX BF %			55d. BMI			56. TEMPERATURE			57. HEART RATE Mandatory Field												
58. BLOOD PRESSURE Mandatory Field						59. RED/GREEN						60. OTHER VISION TEST																					
a. 1ST			b. 2ND			c. 3RD																											
SYS. Mandatory Field			SYS.			SYS.																											
DIAS. Mandatory Field			DIAS.			DIAS.																											
61. DISTANCE VISION				62. REFRACTION				<input type="checkbox"/> AUTO		<input type="checkbox"/> MANIFEST		<input type="checkbox"/> 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		EX		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD																			
65. ACCOMMODATION				66. COLOR VISION (Pass/Fail and Score)						67. DEPTH PERCEPTION (Pass/Fail and Score)																							
Right		Left		PIP N/A		RED/ GREEN		Color Dx		AFVT		RANDOT/ MCST																					
68. FIELD OF VISION						69. NIGHT VISION						70. INTRAOCULAR PRESSURE																					
												O.D.		O.S.																			
71a. AUDIOMETER Unit Serial Number Mandatory Field						71b. Unit Serial Number						72a. READING ALLOUD TEST:		<input type="checkbox"/> SAT		<input type="checkbox"/> UNSAT																	
Date Calibrated (YYYYMMDD) Mandatory Field						Date Calibrated (YYYYMMDD)						72b. VALSALVA:		<input type="checkbox"/> SAT		<input type="checkbox"/> UNSAT																	
HZ		500		1000		2000		3000		4000		6000		HZ		500		1000		2000		3000		4000		6000		72c. OTHER TESTING					
Left		Mandatory Field												Left		x		x		x		x		x		x							
Right		Mandatory Field												Right		x		x		x		x		x		x							
73. NOTES AND/OR INTERVAL HISTORY																																	

89. ADDITIONAL REMARKS

Remarks if it applies to the provider or N/A