

<b>REPORT OF MEDICAL EXAMINATION</b>		<b>1. DATE OF EXAMINATION</b> (YYYYMMDD) Mandatory Field		<b>2a. SOCIAL SECURITY NUMBER</b> Mandatory Field		<b>2b. DoD ID NUMBER</b> (If applicable) Mandatory Field		
<b>PRIVACY ACT STATEMENT</b>								
<p><b>AUTHORITY:</b> 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, <b>Regular components: qualifications, term, grade;</b> 10 U.S.C. 507, <b>Extension of enlistment for members needing medical care or hospitalization;</b> 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.</p> <p><b>PRINCIPAL PURPOSE(S):</b> 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.</p> <p><b>ROUTINE USE(S):</b> The Routine Uses are listed in the applicable system of records notice found at: <a href="http://dpcl.d.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/">http://dpcl.d.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/</a></p> <p><b>DISCLOSURE:</b> 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.</p>								
<b>3. LAST NAME - FIRST NAME - MIDDLE NAME</b> (Suffix) Mandatory Field			<b>4. HOME ADDRESS</b> (Street, Apartment Number, City, State and Zip Code) Mandatory Field			<b>5a. HOME TELEPHONE NUMBER</b> (Include Area Code) Mandatory Field	<b>5b. E-MAIL ADDRESS</b> Mandatory Field	
<b>6. GRADE/RANK</b> Mandatory Field	<b>7. DATE OF BIRTH</b> (YYYYMMDD) Mandatory Field	<b>8. AGE</b> Mandatory Field	<b>9a. BIRTH SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female Mandatory Field	<b>9b. PREFERRED GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female Mandatory Field	<b>10a. ETHNIC CATEGORY</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino		<b>10b. RACIAL CATEGORY</b> (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	
<b>11. TOTAL YEARS GOVERNMENT SERVICE</b> a. MILITARY b. CIVILIAN		<b>12. AGENCY</b> (Non-Service Members Only)			<b>13. ORGANIZATION UNIT AND UIC/CODE</b>			
<b>14a. RATING OR SPECIALTY</b> (Aviators Only)			<b>14b. TOTAL FLYING TIME</b>			<b>14c. LAST SIX MONTHS</b>		
<b>15a. SERVICE</b> <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard Mandatory Field		<b>15b. COMPONENT</b> <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard Mandatory Field	<b>15c. PURPOSE OF EXAMINATION</b> <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			<b>16. NAME OF EXAMINING LOCATION, AND ADDRESS</b> (Include Zip Code) Mandatory Field		
<b>MEDICAL EVALUATION</b> (Check each item in appropriate column. Enter "NE" if not evaluated.) Mandatory Field					<b>43. DENTAL DEFECTS AND DISEASE</b> (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"/> Mandatory Field Class _____			
				<b>Normal</b>	<b>Abnormal</b>	<b>NE</b>		
17. Head, face, neck and scalp				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
18. Nose				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
19. Sinuses				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
20. Mouth and throat				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
22. Tympanic Membranes (Perforation)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
23. Eyes - General				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
24. Ophthalmoscopic				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
25. Pupils (Equality and reaction)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
26. Ocular motility (Associated parallel movements, nystagmus)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
27. Heart (Thrust, size, rhythm, sounds)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
28. Lungs and chest (Include breasts)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
29. Vascular system (Varicosities, etc.)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
31. Abdomen and viscera (Include hernia)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
32. External genitalia (Genitourinary)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
33. Upper extremities				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
34. Lower extremities (Except feet)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
35. Feet (Check category)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
35a. <input type="checkbox"/> Normal Arch <input type="checkbox"/> Pes Planus <input type="checkbox"/> Pes Cavus				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
35b. <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
35c. <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Rigid				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
36. Spine, other musculoskeletal				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
37. Body marks, scars, tattoos				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
38. Skin, lymphatics				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
39. Neurologic				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
40. Psychiatric (Specify any personality disorder)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
41. Pelvic (Females only)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
42. Endocrine				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>44. NOTES:</b> (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.)								

<b>LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)</b> Mandatory Field						<b>SOCIAL SECURITY NUMBER</b> Mandatory Field						<b>DoD ID NUMBER</b> Mandatory Field											
<b>LABORATORY FINDINGS</b>																							
<b>45. URINALYSIS</b>			<b>a. Albumin</b> Mandatory Field			<b>b. Sugar</b> Mandatory Field			<b>46. URINE HCG</b> Mandatory Field (If female)			<b>47. H/H</b>			<b>48. BLOOD TYPE</b>								
<b>TESTS</b>			<b>RESULTS</b>						<b>HIV SPECIMEN ID LABEL</b> Mandatory Field						<b>DRUG TEST SPECIMEN ID LABEL</b>								
<b>49. HIV</b>			Mandatory Field																				
<b>50. DRUGS</b>			Mandatory Field																				
<b>51. ALCOHOL</b>			Mandatory Field																				
<b>52. OTHER</b> Mandatory Field			Hemoglobin, Hematocrit, Total Cholesterol, (39+ CVSP, "PSA Male")																				
<b>a. PAP SMEAR</b>			If Female																				
<b>b. EKG</b>			(39 & over)																				
<b>c. CXR</b>																							
<b>MEASUREMENTS AND OTHER FINDINGS</b>																							
<b>53. HEIGHT (in.)</b> Mandatory Field			<b>54. WEIGHT (lbs.)</b> Mandatory Field			<b>55a. MIN WGT</b>			<b>55b. MAX WGT</b>			<b>55c. MAX BF %</b>			<b>55d. BMI</b>			<b>56. TEMPERATURE</b>			<b>57. HEART RATE</b> Mandatory Field		
<b>58. BLOOD PRESSURE</b> Mandatory Field									<b>59. RED/GREEN</b> Ishihara Test						<b>60. OTHER VISION TEST</b>								
<b>a. 1ST</b>			<b>b. 2ND</b>			<b>c. 3RD</b>																	
SYS. Mandatory Field			SYS.			SYS.																	
DIAS. Mandatory Field			DIAS.			DIAS.																	
<b>61. DISTANCE VISION</b> Mandatory Field			<b>62. REFRACTION</b> <input type="checkbox"/> AUTO <input type="checkbox"/> MANIFEST <input type="checkbox"/> CYCLO						<b>63. NEAR VISION</b>														
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:									
<b>64. HETEROPHORIA</b>																							
ES		EX		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD									
<b>65. ACCOMMODATION</b>			<b>66. COLOR VISION</b> (Pass/Fail and Score) Ishihara Test						<b>67. DEPTH PERCEPTION</b> (Pass/Fail and Score) Mandatory Field														
Right		Left		PIP Mandatory Field		RED/GREEN Mandatory Field		Color Dx Mandatory Field		AFVT Mandatory Field		RANDOT/MCST Mandatory Field											
<b>68. FIELD OF VISION</b>						<b>69. NIGHT VISION</b>						<b>70. INTRAOCULAR PRESSURE</b>											
												O.D.			O.S.								
												<b>71a. AUDIOMETER</b> Unit Serial Number Mandatory Field			<b>71b.</b> Unit Serial Number						<b>72a. READING ALOUD TEST:</b> <input type="checkbox"/> SAT <input type="checkbox"/> UNSAT		
Date Calibrated (YYYYMMDD) Mandatory Field			Date Calibrated (YYYYMMDD)						<b>72b. VALSALVA:</b> <input type="checkbox"/> SAT <input type="checkbox"/> UNSAT														
HZ		500		1000		2000		3000		4000		6000		<b>72c. OTHER TESTING</b>									
Left		Mandatory Field						Left															
Right								Right															
<b>73. NOTES AND/OR INTERVAL HISTORY</b>																							



**89. ADDITIONAL REMARKS**