

REPORT OF MEDICAL EXAMINATION			1. DATE OF EXAMINATION (YYYYMMDD)		2a. SOCIAL SECURITY NUMBER		2b. DoD ID NUMBER (If applicable)		
PRIVACY ACT STATEMENT									
<p>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.</p> <p>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.</p> <p>ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcl.dod.mil/privacy/SCORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/</p> <p>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.</p>									
3. LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)			4. HOME ADDRESS (Street, Apartment Number, City, State and Zip Code)			5a. HOME TELEPHONE NUMBER (Include Area Code)		5b. E-MAIL ADDRESS	
6. GRADE/RANK		7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9a. BIRTH SEX	9b. PREFERRED GENDER	10a. ETHNIC CATEGORY		10b. RACIAL CATEGORY (Select one)	
E5				<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)			13. ORGANIZATION UNIT AND UIC/CODE				
a. MILITARY		b. CIVILIAN	DEPARTMENT OF THE ARMY						
14a. RATING OR SPECIALTY (Aviators Only)			14b. TOTAL FLYING TIME			14c. LAST SIX MONTHS			
15a. SERVICE		15b. COMPONENT		15c. PURPOSE OF EXAMINATION			16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)		
<input checked="" type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard		<input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input checked="" type="checkbox"/> National Guard		<input type="checkbox"/> Enlistment <input type="checkbox"/> Retirement <input type="checkbox"/> Commission <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Retention <input type="checkbox"/> ROTC Scholarship Program <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input checked="" type="checkbox"/> Other COMMISSIONING			Brooke Army Medical Center Aviation Medicine Clinic 3051 Garden Ave, Bldg 1279 Fort Sam Houston, TX 78234		
MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)						43. DENTAL DEFECTS AND DISEASE Acceptable <input checked="" type="checkbox"/> (Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.) Not Acceptable <input type="checkbox"/> Class II			
				Normal	Abnormal	NE			
17. Head, face, neck and scalp				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
18. Nose				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
19. Sinuses				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20. Mouth and throat				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
21. Ears - General (int. and ext. canals/Auditory acuity under item 71)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
22. Tympanic Membranes (Perforation)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
23. Eyes - General				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
24. Ophthalmoscopic				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25. Pupils (Equality and reaction)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
26. Ocular motility (Associated parallel movements, nystagmus)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
27. Heart (Thrust, size, rhythm, sounds)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
28. Lungs and chest (Include breasts)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
29. Vascular system (Varicosities, etc.)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
31. Abdomen and viscera (Include hernia)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
32. External genitalia (Genitourinary)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
33. Upper extremities				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
34. Lower extremities (Except feet)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
35. Feet (Check category)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
35a. <input checked="" 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				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
37. Body marks, scars, tattoos				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
38. Skin, lymphatics				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
39. Neurologic				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
40. Psychiatric (Specify any personality disorder)				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
41. Pelvic (Females only)				<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	#41: N/A		
42. Endocrine				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)	SOCIAL SECURITY NUMBER	DoD ID NUMBER
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LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	b. Sugar	46. URINE HCG	47. H/H	48. BLOOD TYPE
TESTS	RESULTS		HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL	
49. HIV					
50. DRUGS					
51. ALCOHOL					
52. OTHER					
a. PAP SMEAR					
b. EKG					
c. CXR					

MEASUREMENTS AND OTHER FINDINGS

63. HEIGHT (in.)	64. WEIGHT (lbs.)	65a. MIN WGT	65b. MAX WGT	65c. MAX BF %	65d. BMI	66. TEMPERATURE	67. HEART RATE
72	214						59

68. BLOOD PRESSURE			69. RED/GREEN	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD	PASS	
SYS.	SYS.	SYS.		
DIAS.	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:
20		—			20		
Left Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Left Uncorr. 20/	Corr. to 20/	Add:
20		—			20		

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 -0/14	RED/GREEN	Color Dx			RANDOT/MCST

68. FIELD OF VISION				69. NIGHT VISION				70. INTRAOCULAR PRESSURE			
								O.D.		O.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	72c. OTHER TESTING			
Left							Left									
Right							Right									

73. NOTES AND/OR INTERVAL HISTORY

AIRBORNE QUALIFIED

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)

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74. EXAMINEE

- IS MEDICALLY QUALIFIED
- IS NOT MEDICALLY QUALIFIED

Commissioning

75. I have been advised of my disqualifying condition(s).

75a. SIGNATURE OF EXAMINEE

75b. DATE (YYYYMMDD)

76. PHYSICAL PROFILE

P	U	L	H	E	S	X	D	PROFILER INITIALS	DATE (YYYYMMDD)
1	1	1	1	1	1	A			

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)

78. SUMMARY OF MEDICAL DIAGNOSES (List diagnoses with item numbers) (Use additional sheets if necessary).

79. RECOMMENDATIONS (Specify) (Use additional sheets if necessary).

Qualified for Commissioning Per DOD instruction 6130.03 and Chapter 2, AR 40-501

AIRBORNE QUALIFIED

80. MEPS WORKLOAD (For MEPS use only)

WKID	ST	DATE (YYYYMMDD)	INITIALS	WKID	ST	DATE (YYYYMMDD)	INITIALS

81. MEDICAL INSPECTION DATE HT WT %BF MAX WT HCG QUAL DISQ EXAMINER'S NAME AND SIGNATURE

MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	EXAMINER'S NAME AND SIGNATURE

82a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

82b. Signature

83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

83b. Signature

84a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)

84b. Signature

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

b. GRADE

c. DATE (YYYYMMDD)

87. WAIVER GRANTED (If yes, date and by whom)

YES

NO

88. NUMBER OF ATTACHED SHEETS

89. ADDITIONAL REMARKS

