**Physical Exam** - DA Form 2807, 2808, labs and hearing test required. Must be conducted after June 2024.

- -2807 Make sure you answer 14c correctly
- -2808 Ensure blocks 53-66 are completed and the form is signed by a physician on the last page.
- Include scanned hearing test and official lab results to include HIV, urinalysis, urine drug screen, Ethanol level and HCG (pregnancy test for females). If the provider has documented a date AND result on the 2808 for HIV, that is acceptable but the other labs require the scanned lab print out.
- If you need a medical waiver, you will have to submit ALL AHLTA documentation associated with the diagnosis as well as a specialist provider's clearance in order for the waiver to be processed. Start collecting this documents now!

Physical exams will be conducted at a Medical Department, MEPS, or MTF and IAW AR 40-501, Chapter 2 and DA PAM 40-502. Physicals marked not qualifed and needing a waiver must be submitted into the Medical Action Tracking System, a module within MEDCHART. An ETP IAW with 4.a.(4) will only be considered after waiver approval. DODMERB physicals are not authorized.

Approved Medical waivers must be included with the entire medical physical when submitting the packet.

## Profile

Profile - (If applicable) - submit copy of profile. P3 profiles are not eligible to apply. P2 profiles with a P2 in the P, H, and E category are considered for a waiver by the SP Corps leadership on a case by case basis. P2 profiles with a P2 in the U, L, S category are not eligible for a waiver. Temporary profiles are considered for a waiver on a case by case basis.

## REPORT OF MEDICAL HISTORY

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

OMB No. 0704-0413 OMB approval expires September, 30 2021

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 the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mo-alex, esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shell 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 ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

## PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary Of Defense For Personnel And Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130,03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended. PRINCIPAL PURPOSE(8): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and vertices disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted.

a0601-270-usmepcom-dod/ DISCLOSURE: Voluntary; however, failure by an applicant to provide the inform	mation may re- nen requesting	and at: http://dpcid.defense.gov/Privacy/SQRNsIndex/DOD-wide-SQRN-Article-View/Artic out in delay or possible rejection of the individual's application to enter the Armed Forces, civilian medical records. For an Armed Forces member, faiture to provide the information to ensure the collected information is filed in the proper individual's record.	An applicant's
WARNING: The information you have given constitutes an \$10,000 fine or both), to anyone making a false statement.	official sta	ternent. Federal law provides severe penalties (up to 5 years confi	nement or a
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)			YMMDD)
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)			
c. EMAIL ADDRESS			
X ALL APPLICABLE BOXES:		7.a. POSITION (Title, Grade, Component)	
6.a. SERVICE b. COMPONENT c. PURP	OSE OF EX	AMINATION	
Navy Reserve Sep Marine Corps National Guard Med	paration dical Board	Other (Specify)  b. USUAL OCCUPATION	
Air Force Reti  8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	rement	ALLERGIES (Including insect bites/stings, foods, medicine or other substitutions).	
Mark each Item "YES" or "NO". Every Item marked "YE HAVE YOU EVER HAD OR DO YOU NOW HAVE:	S" must b	e fully explained in Item 29 on Page 2.	YES NO
10.a. Tuberculosis	0 0	f. Foot trouble (e.g., pain, coms, bunions, etc.)	0 0
b. Lived with someone who had tuberculosis	ŏŏ	g. Impaired use of arms, legs, hands, or feet	0 0
c. Coughed up blood	0 0	h. Swotlen or painful joint(s)	0 0
<li>d. Asthma or any breathing problems related to exercise, weather, pollens, etc.</li>	0 0	Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	0 0
e. Shortness of breath	00	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	0 0
f. Bronchitis	00	<ul> <li>k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.</li> </ul>	0 0
g. Wheezing or problems with wheezing	00	I. Bone, joint, or other deformity	0 0
h. Been prescribed or used an inhaler	0 0	m, Plate(s), screw(s), rod(s) or pin(s) in any bone	0 0
i. A chronic cough or cough at night	0 0	n. Broken bone(s) (cracked or fractured)	0 0
j. Sinusitis	0 0	13.a. Frequent indigestion or heartburn	0 0
k. Hay fever	0 0	b. Stomach, liver, intestinal trouble, or ulcer	0 0
I. Chronic or frequent colds  11.a. Severe tooth or gum trouble	0 0	c. Gall bladder trouble or gallstones d. Jaundice or hepatitis (liver disease)	0 0
b. Thyroid trouble or goiter	0 0	e. Rupture/hemia	0 0
c. Eye disorder or trouble	0 0	f. Rectal disease, hemorrhoids or blood from the rectum	0 0
d. Ear, nose, or throat trouble	0 0	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	0 0
e. Loss of vision in either eye	0 0	h. Frequent or painful urination	o o
f. Worn contact lenses or glasses	0 0	i. High or low blood sugar	0 0
g. A hearing loss or wear a hearing aid	0 0	j. Kidney stone or blood in urine	0 0
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	0 0	k. Sugar or protein in urine	0 0
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	0 0	Sexually transmitted disease (syphilis, gonorrhee, chiamydia, genital warts, risrpes, etc.)	0 0
b. Arthritis, rheumatism, or bursitis	0 0	14.a. Adverse reaction to serum, food, insect stings or medicine	0 0
c. Recurrent back pain or any back problem	0 0	b. Recent unexplained gain or loss of weight	0 0
d. Numbness or tingling	0 0	c. Currently in good health (If no, explain in Item 29 on Page 2.)	0 0
e, Loss of finger or toe	00	d. Tumor, growth, cyst, or cancer	0 0

15.a. Dizziness or fainting spetis  b. Frequent or severe headache  c. A head injury, memory loss or amnesia  d. Paratysis  e. Seizures, convulsions, epilepay or fits  f. Car, train, sea, or air sickness  g. A period of unconsciousness or concussion  h. Meningitis, encephalitis, or other neurological problems  h. Meningitis, encephalitis, or other neurological problems  c. Pain or pressure in the chest  d. Palpitation, pounding heart or abnormal heartbeat  e. Heart trouble or murmur  f. High or low blood pressure  c. Loss of memory or amnesia, or neurological symptoms  d. Frequent trouble aleeping  e. Received counseling of any type  f. Depression or excessive worry  g. Been evaluated or treated for a mental condition  h. Attempted suicide  b. A change of menstrual pattern  c. A change of menstrual period (YYYYMMDD)   15. FEMALES ONLY. Have you ever had or do you now have:  a. Treatment for a gynecological (female) disorder  d. First dey of last menstrual period (YYYYMMDD)	HAVE YOU EVER HAD OR DO YOU NOW HAVE:  15.6. Dizziness or fainting spells  D. Frequent or severe headache C. A head injury, memory loss or amnesia  D. Paralysis C. A head injury, memory loss or amnesia C. A head injury, memory loss or amnesia C. A head injury, memory loss or amnesia C. A head injury, memory loss or annesia C. A head injury, memory loss or amnesia C. A head injury, memory loss or amnesia C. A paralysis C. A period of unconsciousness or concussion D. Meningitis, encephalitis, or other neurological problems C. A period of unconsciousness or concussion D. Prolonged bleeding (as after an injury or tooth extraction, etc.) C. Pain or pressure in the othest C. Habitual stammering or stuttering C. Loss of memory or amnesis, or neurological symptoms C. Loss of memory or amnesis, or neurological symptoms C. Loss of memory or amnesis, or neurological symptoms C. Propression or excessive worny C. Depression or excessive worny C. A pathormal PAP smears C. A pathormal PAP smears C. A pathormal PAP smears C. Frequent trouble sleeping C. A period of unconsciousid (manular provided in the past 5 years for object of the past 5 years for object	EYOU EVER HAD OR DO YOU NOW HAVE:  Discisses or fainting spells  OOD  Frequent or severe headache A head injury, memory loss or amnesia OOD  Paratysis Seizures, convulsions, epilepsy or fits OOD  Car, train, sea, or all sickness OOD  Meningilis, encephalitis, or other neurological problems Rheumatic fever Palotise for win mumur Palotinor or pressure in the chest OOD  Paln or pressure in the chest OOD  Renounding lass after an injury or tooth extraction, etc.) OP alm or pressure in the chest OOD  Renounding heart or abnormal heartbeat Heart trouble or mumur High or low blood pressure OOD  Nervous trouble of any sort (entiety or panic attacks) Habitual stammering or amnesia, or neurological symptoms Prequent trouble sleeping OOD  Received counseling of any type ODepression or axcessive worty ODepression or axcessive morty ODepression or or axcessive morty ODepression or axcessive morty ODepression or axcessive morty ODepression or or axcess	HAVE YOU EVER HAD OR DO YOU NOW HAVE:  15.a. Disziness or fainting spells  D. Frequent or severe headache  C. A head fujry', memory loss or amnesis  D. Frequent or severe headache  C. A head fujry', memory loss or amnesis  D. Frequent or severe headache  C. A head fujry', memory loss or amnesis  D. Frequent or severe headache  C. A head fujry', memory loss or amnesis  D. Frequent or severe headache  D. Frequent or severe headache  C. A painting spells  D. Frequent or severe headache  D. Habitus to send, it send, it send, it send, it send, it send.  D. Have you ever been relised employment or been unable to hold a job or stay in school because of:  L. Inability to chemicals, dust, sunlight, etc.  D. Inability to perform certain motions  D. Inability to stand, at kneel, edwn, etc.  J. Have you ever been treated in an Emergency Room?  If yes, for whiel?  Have you ever head any illens or injury ther than those affects or severe head any illens or injury the sev	HAVE YOU EVER HAD OR DO YOU NOW HAVE:  15.a. Disziness or fainting spells  D. Frequent or severe headache C. A head flighty, memory loss or amnesis C. Car, train, sea, or air sickness C. G. Extrain, sea, or air sickness C. G. Extrain, sea, or air sickness C. D. How honglitis, encephalitis, or other neurological problems C. Pala or pressure in the chest C. Heart touble or murrur C. D. Habitus stammering or stuttering C. Loss of memory or amnesis, or neurological symptoms C. Loss of memory or amnesis, or neurological symptoms C. Received counseling of any type C. Depression or excessive worry C. Been evaluated or treated for a mental condition C. Any abnormal PAP smears C. Expriant Town of the condition of the	LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)			SOCIAL SECURITY NUMBER   DoD ID NUMBER (If applica	DoD ID NUMBER (If applicable)				
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(if yes, specify when, where, why, and name of doctor and complete address or forcipled or when the address or injury other than tho	Setzures, convulsions, epilepsy or fits  Car, train, sea, or air sickness  A period of unconsciousness or concussion  Chemingtis, encephalitis, or other neurological problems  Rheumatic fewer  Prolonged bleeding (as after an injury or tooth extraction, etc.)  Palin or pressure in the chest  Palpitation, pounding heart or abnormal heartbeat  Heart trouble or murmur  High or low blood pressure  Nervous trouble of any sort (analety or panic affacks)  Hebituals stammering or stuttering  Loss of memory or amnesia, or neurological symptoms  Received counseling of any type  Depression or excessive worry  Been evaluated or treated for a mental condition  Attempted suicide  EMALES ONLY. 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h. Meningitis, encephalitis, or other neurological problems  O 16.a. Rheumatic fever b. Prolonged bleeding (as after an injury or tooth extraction, etc.) c. Pain or pressure in the cheest d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur f. High or low blood pressure  17.a. Nervous trouble of any sort (anxiety or panic attacks) b. Habitual stammening or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent trouble steeping e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs a. Treatment for a gynecological (female) disorder b. A change of menstrual pattern c. Any abnormati PAP amears f. Any abnormati PAP amears f. Press and f. First day of last menstrual period (YYYYMMDD)  29. EXPLANATION OF "YES" ANSWER(8) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical	h. Meningitis, encephalitis, or other neurological problems  O  16.a. Rheumatic fever  D  Pelonged bleeding (as after an injury or tooth extraction, etc.)  C  Paln or pressure in the chest  D  Paln or pressure in the chest  D  High or low blood pressure  High or low blood pressure  C  Loss of memory or amnesis, or neurological symptoms  D  Frequent trouble sleeping  Received counseling of any type  P  Depression or excessive worry  Been evaluated or treated for a mental condition  Attempted suicide  L Used lilegal drugs or abused prescription drugs  Received counseling pAP smear  A reatment for a gynecological (female) disorder  D  A change of menstrual patterm  A restinativel patterm  C  Any abnormal PAP smear  A restinativel patterm  C  A pate of test PAP amear (YYYYMMDD)  Be call the standard of the pattern of the pa	Meningitis, encephalitis, or other neurological problems  O O Palmor pressure in the chest  Palpitation, pounding heart or abnormal heartbeat  High or low blood pressure  Nervous trouble of any sort (enxiety or panic attacks)  Hereat trouble or murmur  Loss of memory or amnesis, or neurological symptoms  Prequent trouble sleeping  Received counseling of any type  Depression or excessive wory  Been evaluated or treated for a mental condition  Attempted suicide  Used lilegal drugs or abused prescription drugs  EMALES ONLY. Have you ever had or do you now have:  Treatment for a gynecological (female) disorder  A change of menstrual pattern  Any abnormal PAP smears  First day of last menstrual period (YYYYMMDD)   XPLANATION OF "YES" ANSWER(8) (Describe answer(s), give defe(s) of problem, name of doctor(s) and/or hospitals), restment given and current medical	16.a. Rheumatic fever  D. Polonged bleeding (as after an injury or tooth extraction, etc.)  D. Polonged bleeding (as after an injury or tooth extraction, etc.)  C. Pain or pressure in the chest  D. Palpitation, pounding heart or abnormal heartbeat  D. Palpitation,	16.a. Rheumatic fever  D. Polonged bleeding (as after an injury or tooth extraction, etc.)  D. Prolonged bleeding (as after an injury or tooth extraction, etc.)  C. Pain or pressure in the chest  D. Palpitation, pounding heart or abnormal heartbeat  D. Heigh or low blood pressure  17.a. Nervous trouble of any sort (anxiety or panic attacks)  D. Heibitual stammering or stuttering  C. Loss of memory or amnesia, or neurological symptoms  D. Frequent trouble steeping  D. Been evaluated or treated for a mental condition  D. Attempted suicide  D. Uased illegal drugs or abused prescription drugs  D. Lated illegal drugs or abused prescription drugs  D. A change of menstrual pattern  C. Any abnormat PAP amears  D. Date of last PAP amear (YYYYMMDD)  29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospitals), irrestment given and current medical	g. A period of unconsciousness or concussion	0	0		0	0			
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Have you over had or do you now have: Treatment for a gynecological (female) disorder Any abnormal PAP smears First day of last menstrual period (YYYYMMDD)  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	b. Prolonged bleeding (as after an injury or tooth extraction, etc.)  c. Pain or pressure in the chest  d. Palpitation, pounding heart or abnormal heartbeat  e. Heart trouble or murmur  f. High or low blood pressure  17.a. Nervous trouble of any sort (enxiety or penic attacks)  b. Habitual stammering or stuttering  c. Loss of memory or amnesia, or neurological symptome  d. Frequent trouble sleeping  e. Received counseling of any type  f. Depression or excessive worry  g. Been evaluated or treated for a mental condition  h. Attempted suicide  i. Used illegal drugs or abused prescription drugs  8. FEMALES ONLY. Have you ever had or do you now have:  a. 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(If yes, specify what kind, granted by whom, and name of doctors and complete address of hospital (s), breatment given and current medical	b. Prolonged bleeding (as after an injury or tooth extraction, etc.)  c. Pain or pressure in the chest  d. Palpitation, pounding heart or abnormal heartbeat  e. Heart trouble or murmur  f. High or low blood pressure  17.a. Nervous trouble of any sort (enxiety or penic attacks)  b. Habitual stammering or stuttering  c. Loss of memory or amnesis, or neurological symptome  d. Frequent trouble sleeping  e. Received counseling of any type  f. Depression or excessive worry  g. Been evaluated or treated for a mental condition  h. Attempted suicide  i. Used lilegal drugs or abused prescription drugs  8. FEMALES ONLY. Have you ever had or do you now have:  a. Treatment for a gyneoclogical (female) disorder  b. A change of menstrual patterm  c. Any abnormat PAP amears  c. Any abnormat PAP amear  d. First day of last menstrual period (YYYYMMDD)  e. 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Have you ever had or do you now have:  Treatment for a gynecological (female) disorder  Any abnormat PAP smears  First day of last menstrual pattem  Are you have been desided (YYYYMMDD)  EXPLANATION OF "YES" ANSWER(\$) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital.)  22. Have you ever had, or have you been advised to have any operations or surgery? (if yes, describe and give age at which  Occurred.)  23. Have you ever had any illness or injury other than those already noted? (if yes, specify when, where, and give details.)  Cocurred.)  24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other practicioners within the past 5 years for other practitioners within the past 5 years for other practicioners within	c. Paln or pressure in the chest d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur f. High or low blood pressure  O 17.a. 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d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur f. High or low blood pressure  17.a. Nervous trouble of any sort (anxiety or panic attacks)  b. Habitual stammering or stuttering c. Loss of memory or amnesis, or neurological symptoms d. Frequent trouble sleeping e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs  a. Treatment for a gynecological (female) disorder b. A change of menstrual patter c. Any abnormal PAP smears d. First day of last menstrual period (YYYYMMDD)  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	d. Paint or pressure in the creek  d. Paintation, pounding heart or abnormal heartbeat  e. Heart trouble or murmur  f. High or low blood pressure  occurred.)  22. Have you ever had, or have you been advised to have any operations or surgery? (if yes, describe and give age at which occurred.)  17.a. Nervous trouble of any sort (anxiety or panic attacks)  occurred.)  23. Have you ever had any illness or injury other than those already noted? (if yes, specify when, where, and give details.)  c. Loss of memory or amnesia, or neurological symptoms  d. Frequent trouble steeping  e. Received counseling of any type  f. Depression or excessive worry  g. Been evaluated or treated for a mental condition  h. Attempted suicide  i. Used illegal drugs or abused prescription drugs  18. FEMALES ONLY. Have you ever had or do you now have:  a. Treatment for a gynecological (female) disorder  b. A change of menstrual pattern  c. Any abnormal PAP smears  d. First day of last menstrual period (YYYYMMDD)  e. Date of last PAP amear (YYYYMMDD)  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 medic.	Palipitation, pounding heart or abnormal heartbeat  Palipitation, pounding heart or abnormal heartbeat  Heart trouble or murmur  Nervous trouble of any sort (enxiety or panic attacks)  Habitual stammering or stuttering  Loss of memory or amnesia, or neurological symptoms  Frequent trouble sleeping  Received counseling of any type  Depression or excessive wory  Been evaluated or treated for a mental condition  Attempted suicide  Used illegal drugs or abused prescription drugs  EMALES ONLY. Have you ever had or do you now have:  Treatment for a gynecological (female) disorder  Any abnormat PAP smears  First day of last menstrual period (YYYYMMDD)  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	d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur  f. High or low blood pressure  17.a. Nervous trouble of any sort (anxiety or panic attacks)  b. Habitual stammering or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent trouble sleeping e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs  18. FEMALES ONLY. Have you ever had or do you now have: a. Treatment for a gynecological (female) disorder b. A change of menstrual pattern c. Any abnormal PAP smears d. First day of last menstrual period (YYYYMMDD)  29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give dete(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical	d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur  f. High or low blood pressure  17.a. Nervous trouble of any sort (anxiety or panic attacks)  b. Habitual stammering or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent trouble sleeping e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide l. Used illegal drugs or abused prescription drugs  18. FEMALES ONLY. Have you ever had or do you now have: a. Treatment for a gynecological (female) disorder b. Achange of menstrual patter c. Any abnormal PAP smears d. First day of last menstrual period (YYYYMMDD) e. Date of last PAP smear (YYYYMMDD)  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	b. Prolonged bleeding (as after an injury or tooth extraction, etc.)				0	О			
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LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)
<ol> <li>EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINE questions 10 - 29. Physician/practitioner may develop by interview significant findings here.)</li> </ol>	ENT DATA (Physician/practitioner shall commonly any additional medical history deemed impo	nent on all positive answers in rtant, and record any
a. COMMENTS		
1-000		
3		
b. TYPED OR PRINTED NAME OF EXAMINER (Lest, First, Middle Initial)	c. SIGNATURE	d. DATE SIGNED
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RE	PORT O	F MEDICA	L EXAMI	NATION		1. DATE O			VIINA	ПО	N		24	. SC	CIA	AL SECURITY	NUMBER	2b. DoD ID N (If applica		
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11. TOTAL YE	ARS GO	VERNMENT	SERVICE	12. AGE	NCY 4	(Non-Service Me	mbe	vs (	Only)		_					13. ORGANIZ	ATION UNIT	F AND UIC/CO	DE	_
a. MILITARY		. CIVILIAN						- •												
14a. RATING	OR SPEC	IALTY (Avia	tors Only)		14	Ib. TOTAL FLYII	NG 1	rimi	E							14c. LA8	T SIX MON	тнз		
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17. Head, face	, neck and	d scalp					<b>-</b>	<u> </u>		7			r	1		xplain in item 4		runnianly molec.	Not Acceptable	L
18. Nose	1 10 10						$\vdash$	۰	Н		Н	+	+	1	1				Class	
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20. Mouth and	thmet						$\vdash$	⊢	Н	$\vdash$	Н	$\dashv$		-					er before each comme	
21. Ears - General (Int. and ext. canais/Auditory acuity under item 71)						am 71)	$\vdash$	⊢	Н	$\vdash$	н	+	╆	+				drawings in iter	n 89 and use additions	3/
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22. Tympanic Membranes (Perforation)							⊢	⊢	Н	$\vdash$	Н	+	+	+	-					
23. Eyes - Ger							⊢	-		-	-	+	+	+	+					
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35a.	Normal	Arch _	Pes Plan	_	<u> </u>	Pes Cavus														
35b.	Mild		Moderati	•	<u> </u>	Severe														
35c.	Asympto	omatic	Sympton	natic		Rigid		61 1	16 S	3. 0	4 13	3 276	40 S	235						
36. Spine, othe	er musculo	oskeletal													]					
37. Body mark	s, scars, t	attoos	meum place erve	-76573								in the								
38. Skin, lymp	hatics						Г							]						
39. Neurologic	:														7					
40. Psychiatric	(Specify	any persona	lity disorder	,	Vind3	Estado				0.0		1			1					
41. Pelvic (Fer	males only	)	33-37												1					
42. Endocrine															1					

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61. DISTAN	ICE VISK	ON .	<u>.                                    </u>		62. REF	RACTION	N [	AUTO		MANI	FE8T		CYC	LO	63. NE	AR VISION	_						
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65. ACCOMMODATION 66. COLOR VISI					R VISION	l (Pass/	Fail and S	core)						67. DE	PTH PERCE	PTI	ON (	Pass	/Fail and	Sco	re)		
Right Left PIP						- 0	RED/ GREEN			Cole Dx				AFVT					RANDO MCST	)T/			
68, FIELD (	OF VISIO	N					69. NIGHT VISION								70. INTRAC	ocu	LAR	PRI					
													O.D.		_		o.s.						
71a. AUDIC	METER	Unit Serial	Numbe	<i>x</i>	-	;	71b. Ur	nit Serial N	t Serial Number							72a. READING ALOUD TEST:			SA	т		UNSAT	
Date Calibro	ated (YY)	(YMMDD)				,	Date C	alibrated (	YYYY	MMDD	<b>)</b>			<del></del>		72b. VALSALVA	a: SAT UNS					UNSAT	
HZ	500	1000	2000	3000	4000	6000	HZ	500	) 1	1000	2000	) 3	000	4000	6000	72c. OTHE	OTHER TESTING						
Left			$\dashv$				Left		$\bot$	$\dashv$		$\bot$	$\dashv$										
Right							Righ	ıt	$\perp$	$\perp$		$\perp$											
73. NOTES	AND/OR	INTERVA	IL HIST	DRY																			

LAST NAI	Æ - FIRS	T NAME - MIL	DOLE NAME	(Suffix)				SOCIA	L SECU	RITY N	UMBER		DoD ID I	NUMBER		
74. EXAM	MEE							76. I ha	ve bee	n advise	ed of my	disqualifyi	na conditio	on(a).		
	IS MEDIC	CALLY QUALI									EXAMIN		_	TE (YYYYMM	DD)	
76. PHYSI			(Oricin ICD									-	ــــــــــــــــــــــــــــــــــــــ			
	CAL PRO				<u> </u>										I	
Р		Ų	L		Н	E		S		Х		D	PROFIL	ER INITIALS	DATE (YYYYMMDD)	
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77. 8IGNII	FICANT O	R DISQUALIF	YING MEDI	CAL DIAGN	IOSES											
ITEM	MEI	DICAL DIAGN	osis	ICD CODE	PROFILE SE	ERIAL	RBJ DAT	TE QUA	LIFIED	DISQL	UALIFIED	EXAMINE	R INITIALS		ER RECEIVED	
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79. RECO	MINIEND/	TIONS (Spec	iny) (Use add	itional shee	is if necessar	y). 										
80. MEP8	WORKL	DAD (For ME	PS use only)													
WKID	ST	DATE (YY	YYMMDD)		INITIAL	S		WKII	·	ST	DATE (1	YYYMMDD	)	INIT	IALS	
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81. MEDK	CAL INSP	ECTION DAT	E HT	· w	т   %В	F   I	MAX WT	HCG	a	UAL	DISQ		EXAMINER'S NAME AND SIGNATURE			
						.:										
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82a. TYPI	ED OR PR	INTED NAME	OF PHYSK	CIAN OR EX	AMINER			82b. Si	gnature							
83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER							83b. Signature									
84a TVD	n OR PE	INTED NAME	OF DENTIS	T OR PHY	RICIAN (Indic	ata whi	ch)	830. 8	gnewn							
4.200		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			·			84b. 8	gnatur	•						
85a. TYPE (Indicate v		INTED NAME	OF REVIE	MING OFFIC	CER/APPRO	/ING A	UTHORIT	85b. 3i	gneturi	•						
86, This 4	xamineti	on has been a	dministrati	vely review	ed for compl	etenee	a and sec	UCRCV.								
a. SIGNA						~~~		c. DATE (YYYYMMDD)								
-	TURE					b. G	RADE					c. I	PATE (YYY	YMMDD)		

Prescribed by: DoDI 1304.2	 	 	
89. ADDITIONAL REMARKS			