REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2a. SOCIAL SECURITY NUMBER	2b. DoD ID NUMBER (If applicable)

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://dpcld.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)	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	9. SEX	10. RACE AND ETHNICITY (Select All That Apply)
			☐ Male ☐ Female	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		

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)
☐ Army ☐ Air Force ☐ Marine Corps ☐ Navy ☐ Coast Guard ☐ USPHS	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Commission ☐ Retention ☐ Separation ☐ Other _____ ☐ Retirement ☐ U.S. Service Academy ☐ ROTC Scholarship Program ☐ Medical Board	

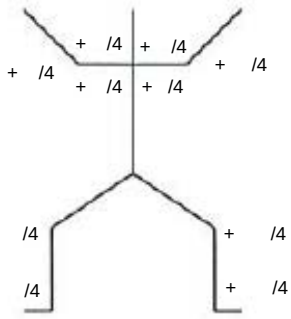
MEDICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnormal	NE
17. Head, face, neck and scalp	☐	☐	☐
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. ☐ Normal Arch ☐ Pes Planus ☐ Pes Cavus			
35b. ☐ Mild ☐ Moderate ☐ Severe			
35c. ☐ Asymptomatic ☐ Symptomatic ☐ 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	☐	☐	☐

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.)*
Acceptable ☐
Not Acceptable ☐
Class _____

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.)*

REFLEXES:
Bicep
Brachioradialis
Tricep



Patellar
Achilles

#22 TM's Mobile to Valsalva Y / N

#39 Neuro Exam:

Mental Status	Normal / Abnormal
A&Ox3	Y / N
CN II-XII Intact	Y / N
Sensation to pinprick/light touch	Y / N
Rapid alternating movements	Y / N
Heel to shin	Normal / Abnormal
Finger to nose	Normal / Abnormal
Gait	Normal / Abnormal
Romberg	Normal / Abnormal
Motor strength 5/5 throughout	Y / N
Babinski reflex	Normal / Abnormal

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

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	b. Sugar	46. URINE HCG	47. H/H	48. BLOOD TYPE
***See Box 73 ***	***See Box 73 ***	***See Box 73 ***	***See Box 73 ***	***See Box 73 ***	***See Box 73 ***

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

53. HEIGHT *(in.)*	54. WEIGHT *(lbs.)*	55a. MIN WGT	55b. MAX WGT	55c. MAX BF %	55d. BMI	56. TEMPERATURE	57. HEART RATE

58. BLOOD PRESSURE			59. RED/GREEN	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANCE VISION		62. REFRACTION ☐ AUTO ☐ MANIFEST ☐ 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	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	**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	6000
Left							Left						
Right							Right						

72c. OTHER TESTING

73. NOTES AND/OR INTERVAL HISTORY

PPD or LTBI Screen Date:_____ Results:_____
CBC Date:_____ Hgb:_____ Hct:_____ WBC:_____ Plt:_____
UA (micro for SO) Date:_____ Glc: _____ Bili: _____ Ket:_____ Blood:_____ Prot:_____ Nitrite:_____ LE:_____ WBC:_____ RBC:_____
Fasting Glc Date:_____ Results:_____
Hep C (if indicated) Date:_____ Results:_____
Blood Type Date:_____ Results:_____
G6PD Date:_____ Results:_____
Sickle Cell Date:_____ Results:_____
Hep A #1 Date:_____ Hep A #2 Date:_____
Hep B #1 Date:_____ Hep B #2 Date:_____ Hep B #3 Date:_____

FEMALE DIVERS
Mammogram Date: _____
Well Woman/PAP Date: _____
Fetal Risk Counseling Date:_____

PHA
Date:

PARACHUTING

PSA (MALE >40) STOOL GUIAC
Date: Date:
Result: Result:

LIPID: RPR
Date:
LDL: Result:
HDL:
TC:
TRIG:

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

74. EXAMINEE

☐ IS MEDICALLY QUALIFIED
☐ IS NOT MEDICALLY QUALIFIED

☐ DIVE ☐ SUB ☐ SO ☐ NFD ☐ Other

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)*

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).*

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

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