# Function As An Operational Medical Officer

## Documentation of the Special Duty Physical and other related forms

# Enabling Objectives

- Describe who needs occupational health physicals/exams based on their profession
- Follow instructions related to undersea medicine
- Document medical care

# References

- NAVMED P-117, Manual of the Medical Department (MANMED), Chapter 15, 16
  - https://www.med.navy.mil/directives/Pages/NAVMEDP-MANMED.aspx

# Conducting and Recording the Examination

Core Forms:

- DD 2807-1 (2018) Report of Medical History
- DD 2808 (2019) Report of Medical Examination
- NAVMED 6150/2 (Rev. 4-70) Special Duty Abstract

Additional Forms

- NAVPERS 1200/6 (Dec 2009), US Military Diving Medical Screening Questionnaire
- NAVMED 6420/2 (March 2019), Health and Reproductive Risk Counseling for Female Submariners and Submarine Candidates

# 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



**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(S):** 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 verifies 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.
**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. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

**WARNING:** The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement.

| 1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | 2.a. SOCIAL SECURITY NO. | b. DoD ID NO. *(If applicable)* | 3. TODAY'S DATE *(YYYYMMDD)* |
|---|---|---|---|
| | | | |

| 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:**

| 6.a. SERVICE | b. COMPONENT | c. PURPOSE OF EXAMINATION |
|---|---|---|
| Army | Regular | Retention |
| Navy | Reserve | Separation |
| Marine Corps | National Guard | Medical Board |
| Air Force | | Retirement |
| Coast Guard | | Other *(Specify)* |

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*

9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

**Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.**

| HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO |
|---|---|---|
| 10.a. Tuberculosis | | |
| b. Lived with someone who had tuberculosis | | |
| c. Coughed up blood | | |
| d. Asthma or any breathing problems related to exercise, weather, pollens, etc. | | |
| e. Shortness of breath | | |
| f. Bronchitis | | |
| g. Wheezing or problems with wheezing | | |
| h. Been prescribed or used an inhaler | | |
| i. A chronic cough or cough at night | | |
| j. Sinusitis | | |
| k. Hay fever | | |
| l. Chronic or frequent colds | | |
| 11.a. Severe tooth or gum trouble | | |
| b. Thyroid trouble or goiter | | |
| c. Eye disorder or trouble | | |
| d. Ear, nose, or throat trouble | | |
| e. Loss of vision in either eye | | |
| f. Worn contact lenses or glasses | | |
| g. A hearing loss or wear a hearing aid | | |
| h. Surgery to correct vision *(RK, PRK, LASIK, etc.)* | | |
| 12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)* | | |
| b. Arthritis, rheumatism, or bursitis | | |
| c. Recurrent back pain or any back problem | | |
| d. Numbness or tingling | | |
| e. Loss of finger or toe | | |
| 12. *(Continued)* | YES | NO |
| f. Foot trouble *(e.g., pain, corns, bunions, etc.)* | | |
| g. Impaired use of arms, legs, hands, or feet | | |
| h. Swollen or painful joint(s) | | |
| i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)* | | |
| j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint | | |
| k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. | | |
| l. Bone, joint, or other deformity | | |
| m. Plate(s), screw(s), rod(s) or pin(s) in any bone | | |
| n. Broken bone(s) *(cracked or fractured)* | | |
| 13.a. Frequent indigestion or heartburn | | |
| b. Stomach, liver, intestinal trouble, or ulcer | | |
| c. Gall bladder trouble or gallstones | | |
| d. Jaundice or hepatitis *(liver disease)* | | |
| e. Rupture/hernia | | |
| f. Rectal disease, hemorrhoids or blood from the rectum | | |
| g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)* | | |
| h. Frequent or painful urination | | |
| i. High or low blood sugar | | |
| j. Kidney stone or blood in urine | | |
| k. Sugar or protein in urine | | |
| l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)* | | |
| 14.a. Adverse reaction to serum, food, insect stings or medicine | | |
| b. Recent unexplained gain or loss of weight | | |
| c. Currently in good health *(If no, explain in Item 29 on Page 2.)* | | |
| d. Tumor, growth, cyst, or cancer | | |



| LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | SOCIAL SECURITY NUMBER | DoD ID NUMBER *(If applicable)* |
|---|---|---|
| | | |

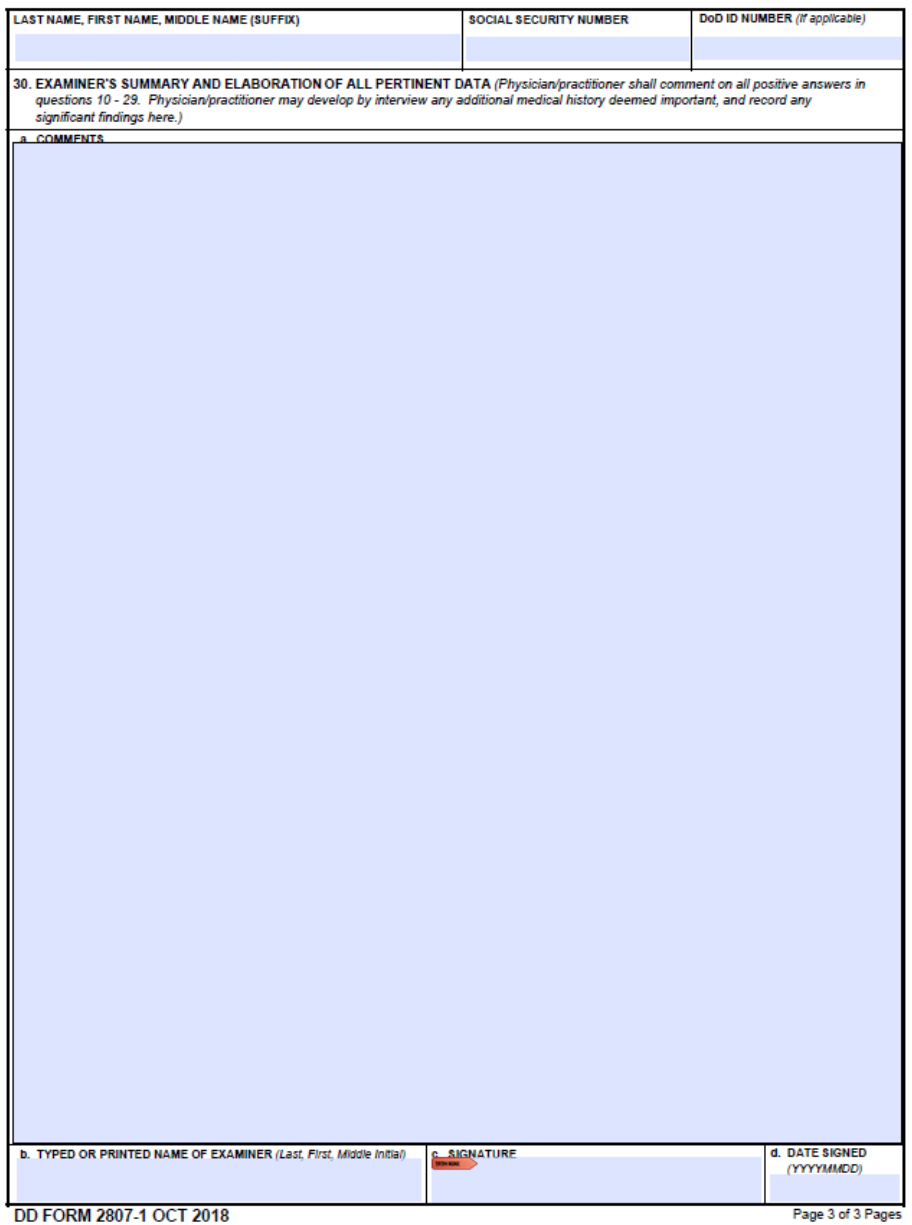
**Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.**

| HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO |
|---|---|---|
| 15.a. Dizziness or fainting spells | | |
| b. Frequent or severe headache | | |
| c. A head injury, memory loss or amnesia | | |
| d. Paralysis | | |
| e. Seizures, convulsions, epilepsy or fits | | |
| f. Car, train, sea, or air sickness | | |
| g. A period of unconsciousness or concussion | | |
| h. Meningitis, encephalitis, or other neurological problems | | |
| 16.a. Rheumatic fever | | |
| 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 *(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)* | | |
| e. Date of last PAP smear *(YYYYMMDD)* | | |

| | YES | NO |
|---|---|---|
| 19. Have you been refused employment or been unable to hold a job or stay in school because of: | | |
| a. Sensitivity to chemicals, dust, sunlight, etc. | | |
| b. Inability to perform certain motions | | |
| c. Inability to stand, sit, kneel, lie down, etc. | | |
| d. Other medical reasons *(If yes, give reasons.)* | | |
| 20. Have you ever been treated in an Emergency Room? *(If yes, for what?)* | | |
| 21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of 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.) | | |
| 24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)* | | |
| 25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)* | | |
| 26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)* | | |
| 27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)* | | |
| 28. Have you ever been denied life insurance? | | |

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 status.)*

**NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."**



| LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | SOCIAL SECURITY NUMBER | DoD ID NUMBER *(If applicable)* |
|---|---|---|
| | | |

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

| b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)* | c. SIGNATURE | d. DATE SIGNED *(YYYYMMDD)* |
|---|---|---|
| | | |

DD FORM 2807-1 OCT 2018 Page 3 of 3 Pages

- DD 2807, Block 30:
  - Examiner will comment on any affirmative or uncertain answers
  - All comments should be annotated:
    - CD = Considered Disqualifying
    - NCD = Not Considered Disqualifying
    - PD = Potentially Disqualifying (temporary only, requires further workup to make CD or NCD determination)

# Conducting and Recording the Examination

- DD 2808 Report of Medical Examination
  - Particular emphasis on positive or negative results related to items on 2807-1
  - Comment sufficiently to facilitate review by another qualified provider

Prescribed by: DoDI 1304.2

# 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 | 9a. BIRTH SEX | 9b. PREFERRED GENDER | 10a. ETHNIC CATEGORY | 10b. RACIAL CATEGORY (Select one) |
|---|---|---|---|---|---|---|
| | | | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Hispanic/Latino ☐ Non Hispanic/Latino | ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ 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 | | |
| | | | |

| 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 | ☐ 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 80 and use additional sheets if necessary.)*



Prescribed by: DoDI 1304.2

| 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 |
|---|---|---|---|---|---|
| | | | | | |

| 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. PULSE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| 58. BLOOD PRESSURE | | | 59. RED/GREEN (Army Only) | 60. OTHER VISION TEST |
|---|---|---|---|---|
| a. 1ST | b. 2ND | c. 3RD | | |
| SYS. | SYS. | SYS. | | |
| DIAS. | DIAS. | DIAS. | | |

| 61. DISTANCE VISION | | | | | | 62. REFRACTION BY ☐ AUTO OR ☐ MANIFEST | | | | | 63. NEAR VISION | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Left Uncorr. 20/ | | Corr. to 20/ | | Sph: | Cyl: | Axis: | | | Left Uncorr. 20/ | | Corr. to 20/ | | Add: | |
| Right Uncorr. 20/ | | Corr. to 20/ | | Sph: | Cyl: | Axis: | | | Right 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 (Test and score/result) | | | | 67. DEPTH PERCEPTION (Test and score/result) | | | |
|---|---|---|---|---|---|---|---|---|---|
| Right | Left | PIP ☐ | | FALANT ☐ | | 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 | | 72c. OTHER TESTING | | |
| Left | | | | | | | | Left | | | | | | | | | | |
| Right | | | | | | | | Right | | | | | | | | | | |

**73. NOTES AND/OR INTERVAL HISTORY**

Prescribed by: DoDI 1304.2

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

| 74. EXAMINEE | 75. I have been advised of my disqualifying condition(s). | |
|---|---|---|
| ☐ IS MEDICALLY QUALIFIED<br>☐ IS NOT MEDICALLY QUALIFIED | 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 |
|---|---|---|---|
| | ☐ | ☐ | |

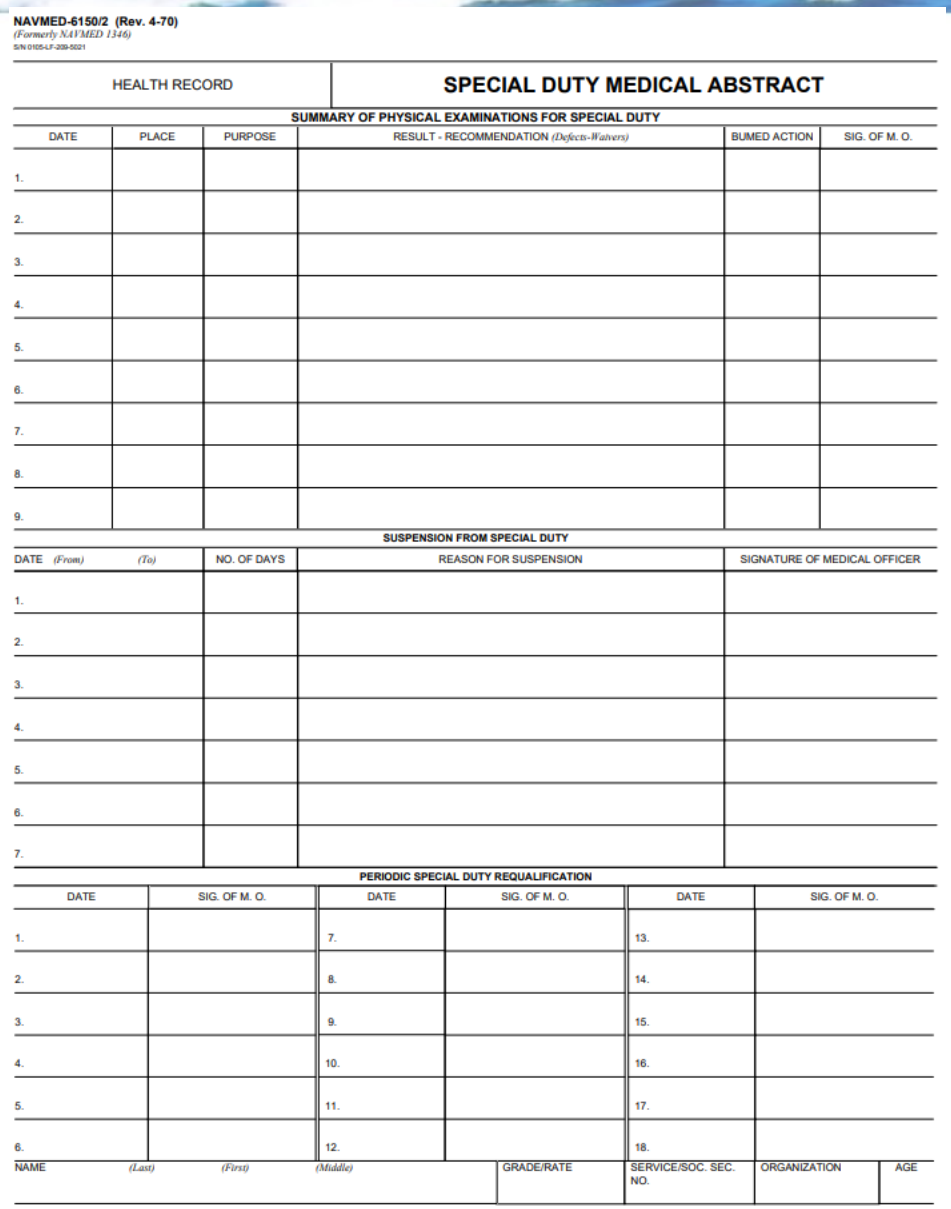
DD FORM 2808, July 2019

Prescribed by: DoDI 1304.2

**89. ADDITIONAL REMARKS**

- Summarize all notable diagnoses in Block 77 or 78
- Annotate all with CD or NCD
  - Anything CD results in NPQ status and will require a waiver

DD FORM 2808, July 2019



NAVMED-6150/2 (Rev. 4-70)
*(Formerly NAVMED 1346)*
S/N 0105-LF-209-5021

HEALTH RECORD | **SPECIAL DUTY MEDICAL ABSTRACT**

**SUMMARY OF PHYSICAL EXAMINATIONS FOR SPECIAL DUTY**

| | DATE | PLACE | PURPOSE | RESULT - RECOMMENDATION *(Defects-Waivers)* | BUMED ACTION | SIG. OF M. O. |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |
| 7. | | | | | | |
| 8. | | | | | | |
| 9. | | | | | | |

**SUSPENSION FROM SPECIAL DUTY**

| | DATE *(From)* *(To)* | NO. OF DAYS | REASON FOR SUSPENSION | SIGNATURE OF MEDICAL OFFICER |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

**PERIODIC SPECIAL DUTY REQUALIFICATION**

| | DATE | SIG. OF M. O. | | DATE | SIG. OF M. O. | | DATE | SIG. OF M. O. |
|---|---|---|---|---|---|---|---|---|
| 1. | | | 7. | | | 13. | | |
| 2. | | | 8. | | | 14. | | |
| 3. | | | 9. | | | 15. | | |
| 4. | | | 10. | | | 16. | | |
| 5. | | | 11. | | | 17. | | |
| 6. | | | 12. | | | 18. | | |

| NAME *(Last)* *(First)* *(Middle)* | GRADE/RATE | SERVICE/SOC. SEC. NO. | ORGANIZATION | AGE |
|---|---|---|---|---|
| | | | | |

- NAVMED 6150/2, Special Duty Abstract
  - Two sided form
  - Name is located at very bottom of front side ONLY
  - Documents which special duties the patient is qualified for

**ALTITUDE TRAINING, AIR COMPRESSION AND OXYGEN TOLERANCE**

| DATE | STATION | TYPE OF RUN-REACTION | SIG. OF M. O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**EXPLOSIVE DECOMPRESSION TRAINING**

| DATE | STATION | ALTITUDES-REACTION | SIG. OF M. O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

**SUBMARINE ESCAPE AND DIVING TRAINING**

| DATE | STATION | TYPE OF RUN-REACTION | SIG. OF M. O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**VISUAL AND DISORIENTATION TRAINING**

| DATE | STATION | TYPE OF TRAINING | SIG. OF M. O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**CENTRIFUGE AND EJECTION SEAT TRAINING**

| DATE | STATION | TYPE OF RUN-REACTIONS | SIG. OF M. O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

REMARKS:

- NAVMED 6150/2, Special Duty Abstract
  - Two sided form
  - NO LOCATION FOR NAME ON THIS SIDE
  - Ensure patient identifiers are present if not printed front-back
  - Documents additional training related to special duties

# Conducting and Recording the Examination

- And now for a closer look at:
  - DD2807
  - DD2808
  - NAVMED 6150/2
- Key:
  - BLUE – patient completes
  - RED – provider/clinic completes
  - BLACK – blank/not used
  - GREEN – dental provider

# 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



**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(S):** 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 verifies 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.
**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. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

**WARNING:** The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement.

| 1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | 2.a. SOCIAL SECURITY NO. | b. DoD ID NO. (If applicable) | 3. TODAY'S DATE (YYYYMMDD) |
|---|---|---|---|
| | | | |

4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)

b. HOME TELEPHONE (Include Area Code)

c. EMAIL ADDRESS

5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)

X ALL APPLICABLE BOXES:

| 6.a. SERVICE | b. COMPONENT | c. PURPOSE OF EXAMINATION |
|---|---|---|
| Army | Regular | Retention |
| Navy | Reserve | Separation |
| Marine Corps | National Guard | Medical Board |
| Air Force | | Retirement |
| Coast Guard | | Other (Specify) |

7.a. POSITION (Title, Grade, Component)

b. USUAL OCCUPATION

**Medications**

**Allergies**

| HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO |
|---|---|---|
| 10.a. Tuberculosis | | |
| b. Lived with someone who had tuberculosis | | |
| c. Coughed up blood | | |
| d. Asthma or any breathing problems related to exercise, weather, pollens, etc. | | |
| e. Shortness of breath | | |
| f. Bronchitis | | |
| g. Wheezing or problems with wheezing | | |
| h. Been prescribed or used an inhaler | | |
| i. A chronic cough or cough at night | | |
| j. Sinusitis | | |
| k. Hay fever | | |
| l. Chronic or frequent colds | | |
| 11.a. Severe tooth or gum trouble | | |
| b. Thyroid trouble or goiter | | |
| c. Eye disorder or trouble | | |
| d. Ear, nose, or throat trouble | | |
| e. Loss of vision in either eye | | |
| f. Worn contact lenses or glasses | | |
| g. A hearing loss or wear a hearing aid | | |
| h. Surgery to correct vision (RK, PRK, LASIK, etc.) | | |
| 12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) | | |
| b. Arthritis, rheumatism, or bursitis | | |
| c. Recurrent back pain or any back problem | | |
| d. Numbness or tingling | | |
| e. Loss of finger or toe | | |

| 12. (Continued) | YES | NO |
|---|---|---|
| f. Foot trouble (e.g., pain, corns, bunions, etc.) | | |
| g. Impaired use of arms, legs, hands, or feet | | |
| h. Swollen or painful joint(s) | | |
| i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) | | |
| j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint | | |
| k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. | | |
| l. Bone, joint, or other deformity | | |
| m. Plate(s), screw(s), rod(s) or pin(s) in any bone | | |
| n. Broken bone(s) (cracked or fractured) | | |
| 13.a. Frequent indigestion or heartburn | | |
| b. Stomach, liver, intestinal trouble, or ulcer | | |
| c. Gall bladder trouble or gallstones | | |
| d. Jaundice or hepatitis (liver disease) | | |
| e. Rupture/hernia | | |
| f. Rectal disease, hemorrhoids or blood from the rectum | | |
| g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) | | |
| h. Frequent or painful urination | | |
| i. High or low blood sugar | | |
| j. Kidney stone or blood in urine | | |
| k. Sugar or protein in urine | | |
| l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.) | | |
| 14.a. Adverse reaction to serum, food, insect stings or medicine | | |
| b. Recent unexplained gain or loss of weight | | |
| c. Currently in good health (If no, explain in Item 29 on Page 2.) | | |
| d. Tumor, growth, cyst, or cancer | | |



| LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | SOCIAL SECURITY NUMBER | DoD ID NUMBER (If applicable) |
|---|---|---|
| | | |

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

| HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO |
|---|---|---|
| 15.a. Dizziness or fainting spells | | |
| b. Frequent or severe headache | | |
| c. A head injury, memory loss or amnesia | | |
| d. Paralysis | | |
| e. Seizures, convulsions, epilepsy or fits | | |
| f. Car, train, sea, or air sickness | | |
| g. A period of unconsciousness or concussion | | |
| h. Meningitis, encephalitis, or other neurological problems | | |
| 16.a. Rheumatic fever | | |
| 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 (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) | | |
| e. Date of last PAP smear (YYYYMMDD) | | |

| | YES | NO |
|---|---|---|
| 19. Have you been refused employment or been unable to hold a job or stay in school because of: | | |
| a. Sensitivity to chemicals, dust, sunlight, etc. | | |
| b. Inability to perform certain motions | | |
| c. Inability to stand, sit, kneel, lie down, etc. | | |
| d. Other medical reasons (If yes, give reasons.) | | |
| 20. Have you ever been treated in an Emergency Room? (If yes, for what?) | | |
| 21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of 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.) | | |
| 24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) | | |
| 25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) | | |
| 26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) | | |
| 27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) | | |
| 28. Have you ever been denied life insurance? | | |

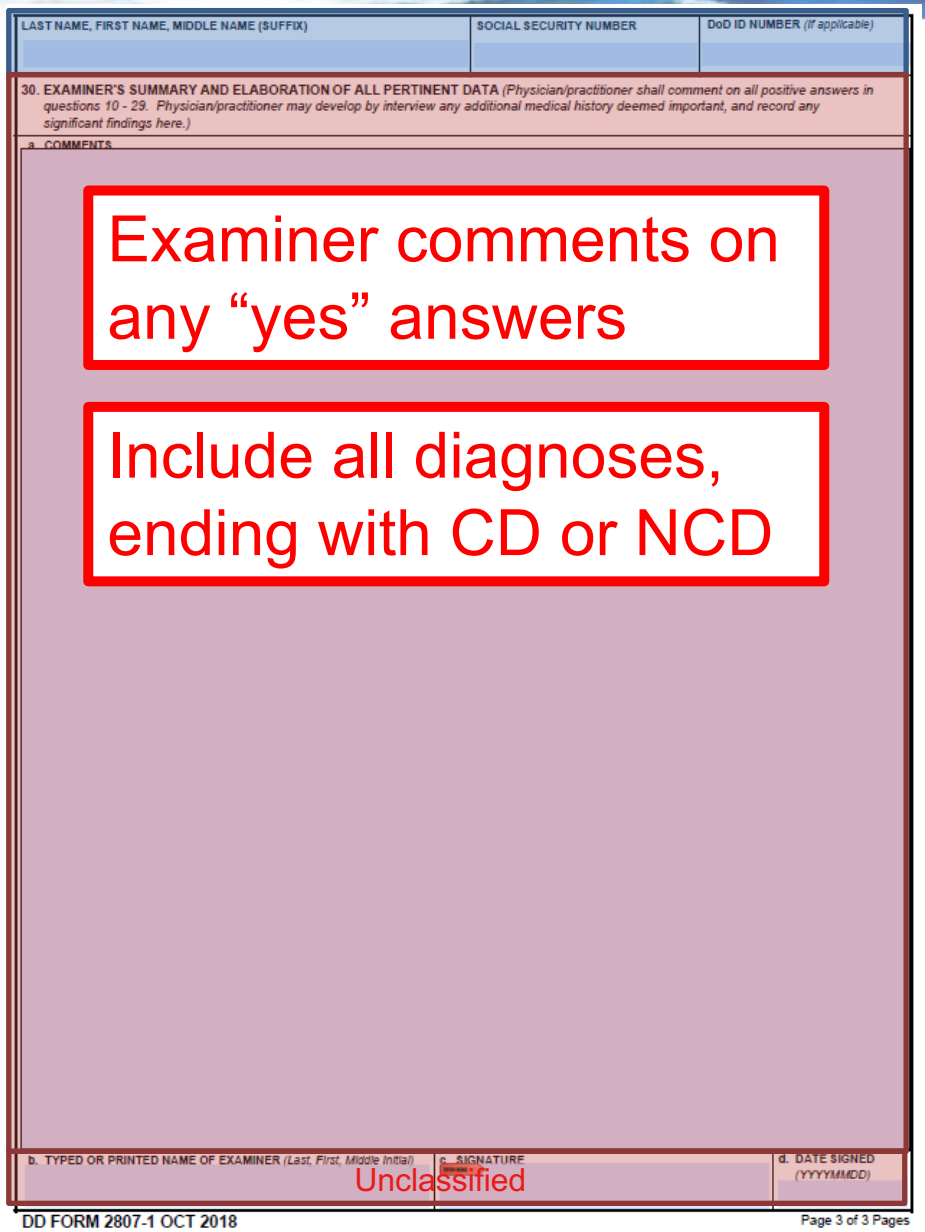
29. EXPLANATION OF "YES" ANSWER(S) (Describe briefly; give date(s), name of doctor(s) and/or hospital(s), treatment given and current medical status.)

**Patient comments on any "yes" answers**

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."



Unclassified


LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | SOCIAL SECURITY NUMBER | DoD ID NUMBER (If applicable)

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)

a. COMMENTS

Examiner comments on any "yes" answers

Include all diagnoses, ending with CD or NCD

b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial) | c. SIGNATURE | d. DATE SIGNED (YYYYMMDD)

Unclassified

DD FORM 2807-1 OCT 2018 Page 3 of 3 Pages

- CD: Considered Disqualifying
- NCD: Not Considered Disqualifying

Best practice:

- Comment on any medications (block 8) or allergies (block 9) followed by CD or NCD

Prescribed by: DoDI 1304.2

**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 | 9a. BIRTH SEX (Male / Female) | 9b. PREFERRED GENDER (Male / Female) | 10a. ETHNIC CATEGORY (Hispanic/Latino / Non Hispanic/Latino) | 10b. RACIAL CATEGORY (Select one) (American Indian or Alaska Native / Asian / Black or African American / White / 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

14a. RATING OR SPECIALTY (Aviators Only) | 14b. TOTAL FLYING TIME | 14c. LAST SIX MONTHS

Army / Air Force / Marine Corps / Navy / Coast Guard
Active Duty / Reserve / National Guard
13c. PURPOSE OF EXAMINATION: Enlistment / Commission / Retention / Separation / Other; Retirement / U.S. Service Academy / ROTC Scholarship Program / Medical Board
(Include Zip Code)

**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 80 and use additional sheets if necessary.)

Include any comments, listed by block number

**EXAMINEE DOES NOT GET TO CHOOSE**

**CAN DEFER ONLY IF WWE HAS BEEN PERFORMED**

DD FORM 2808, July 2019

Page 1 of 4

Prescribed by: DoDI 1304.2

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

| TESTS | RESULTS |
|---|---|
| 49. HIV | |
| 50. DRUGS | |
| 51. ALCOHOL | |
| 52. OTHER | |
| a. PAP SMEAR | |
| b. EKG | |
| c. CXR | |

HIV SPECIMEN ID LABEL | DRUG TEST SPECIMEN ID LABEL

**MEASUREMENTS AND OTHER FINDINGS**

53. HEIGHT (In.) | 54. WEIGHT (lbs.) | 55a. MIN WGT | 55b. MAX WGT | 55c. MAX BF % | 55d. BMI | 56. TEMPERATURE | 57. PULSE

58. BLOOD PRESSURE: a. 1ST (SYS. / DIAS.) | b. 2ND (SYS. / DIAS.) | c. 3RD (SYS. / DIAS.)

59. RED/GREEN (Army Only) | 60. OTHER VISION TEST

61. DISTANCE VISION: Left Uncorr. 20/ | Corr. to 20/ | Sph: | Cyl: | Axis: | Right Uncorr. 20/ | Corr. to 20/ | Sph: | Cyl: | Axis:

62. REFRACTION BY ☐ AUTO OR ☐ MANIFEST

63. NEAR VISION: Left Uncorr. 20/ | Corr. to 20/ | Add: | Right Uncorr. 20/ | Corr. to 20/ | Add:

64. HETEROPHORIA: ES | EX | R.H. | L.H. | Prism div. | Prism Conv CT | NPR | PD

65. ACCOMMODATION: Right | Left

66. COLOR VISION (Test and score/result): PIP ☐ | FALANT ☐ | Color Dx ☐

67. DEPTH PERCEPTION (Test and score/result): AFVT ☐ | RANDOT/MCST ☐

68. FIELD OF VISION

69. NIGHT VISION

70. INTRAOCULAR PRESSURE: O.D. | O.S.

71a. AUDIOMETER Unit Serial Number

Date Calibrated (YYYYMMDD)

| | HZ | 500 | 1000 | 2000 | 3000 | 4000 | 6000 |
|---|---|---|---|---|---|---|---|
| Left | | | | | | | |
| Right | | | | | | | |

71b. Unit Serial Number

Date Calibrated (YYYYMMDD)

| | HZ | 500 | 1000 | 2000 | 3000 | 4000 | 6000 |
|---|---|---|---|---|---|---|---|
| Left | | | | | | | |
| Right | | | | | | | |

72a. READING LOUD TEST: SAT / UNSAT

72b. VALSALVA: SAT / UNSAT

72c. OTHER TESTING

73. NOTES AND/OR INTERVAL HISTORY

Additional labs/studies not documented above or comments here

DD FORM 2808, July 20

of 4

Date of exam

Prescribed by: DoDI 1304.2

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 | 9a. BIRTH SEX (Male / Female) | 9b. PREFERRED GENDER (Male / Female) | 10a. ETHNIC CATEGORY (Hispanic/Latino / Non Hispanic/Latino) | 10b. RACIAL CATEGORY (Select one) (American Indian or Alaska Native / Asian / Black or African American / White / Native Hawaiian or Other Pacific Islander)

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 (Army / Air Force / Marine Corps / Navy / Coast Guard) | 15b. COMPONENT (Active Duty / Reserve / National Guard) | 15c. PURPOSE OF EXAMINATION (Enlistment / Commission / Retention / Separation / Other / Retirement / U.S. Service Academy / ROTC Scholarship Program / Medical Board) | 16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)

**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 80 and use additional sheets if necessary.)

EXAMINEE DOES NOT GET TO CHOOSE

CAN DEFER ONLY IF WWE HAS BEEN PERFORMED

DD FORM 2808, July 2019 — Page 1 of 4

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

| TESTS | RESULTS |
|---|---|
| 49. HIV | |
| 50. DRUGS | |
| 51. ALCOHOL | |
| 52. OTHER | |
| a. PAP SMEAR | |
| b. EKG | |
| c. CXR | |

HIV SPECIMEN ID LABEL | DRUG TEST SPECIMEN ID LABEL

**MEASUREMENTS AND OTHER FINDINGS**

53. HEIGHT (In.) | 54. WEIGHT (lbs.) | 55a. MIN WGT | 55b. MAX WGT | 55c. MAX BF % | 55d. BMI | 56. TEMPERATURE | 57. PULSE

58. BLOOD PRESSURE: a. 1ST | b. 2ND | c. 3RD (SYS. / DIAS.)

59. RED/GREEN (Army Only) | 60. OTHER VISION TEST

61. DISTANCE VISION: Left Uncorr. 20/ | Corr. to 20/ | Sph: | Cyl: | Axis:
Right Uncorr. 20/ | Corr. to 20/ | Sph: | Cyl: | Axis:

62. REFRACTION BY ☐ AUTO OR ☐ MANIFEST

63. NEAR VISION: Left Uncorr. 20/ | Corr. to 20/ | Add:
Right Uncorr. 20/ | Corr. to 20/ | Add:

Prism div. | Prism Conv | and score/result)

ANT ☐ | Color Dx ☐

Audiogram calibration date

TM movement with Valsalva

68. FIELD OF VISION

69. NIGHT VISION

O.D. | O.S.

71a. AUDIOMETER Unit Serial Number

Date Calibrated (YYYYMMDD)

| HZ | 500 | 1000 | 2000 | 3000 | 4000 | 6000 |
|---|---|---|---|---|---|---|
| Left | | | | | | |
| Right | | | | | | |

71b. Unit Serial Number

Date Calibrated (YYYYMMDD)

| HZ | 500 | 1000 | 2000 | 3000 | 4000 | 6000 |
|---|---|---|---|---|---|---|
| Left | | | | | | |
| Right | | | | | | |

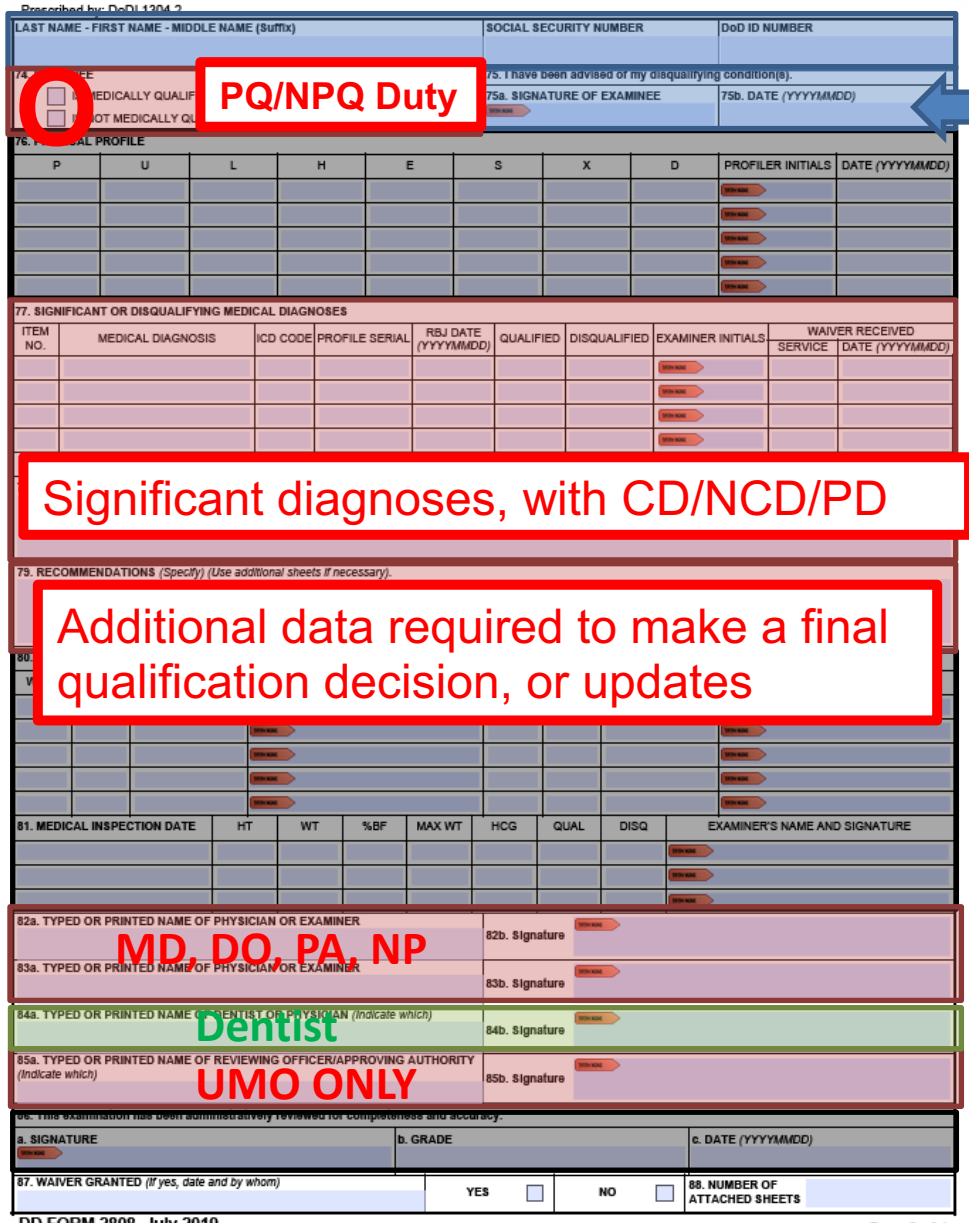
72a. READING ALOUD TEST: SAT / UNSAT

72b. VALSALVA: SAT / UNSAT

72c. OTHER TESTING

73. NOTES AND/OR INTERVAL HISTORY

DD FORM 2808, July 2019 — Page 2 of 4

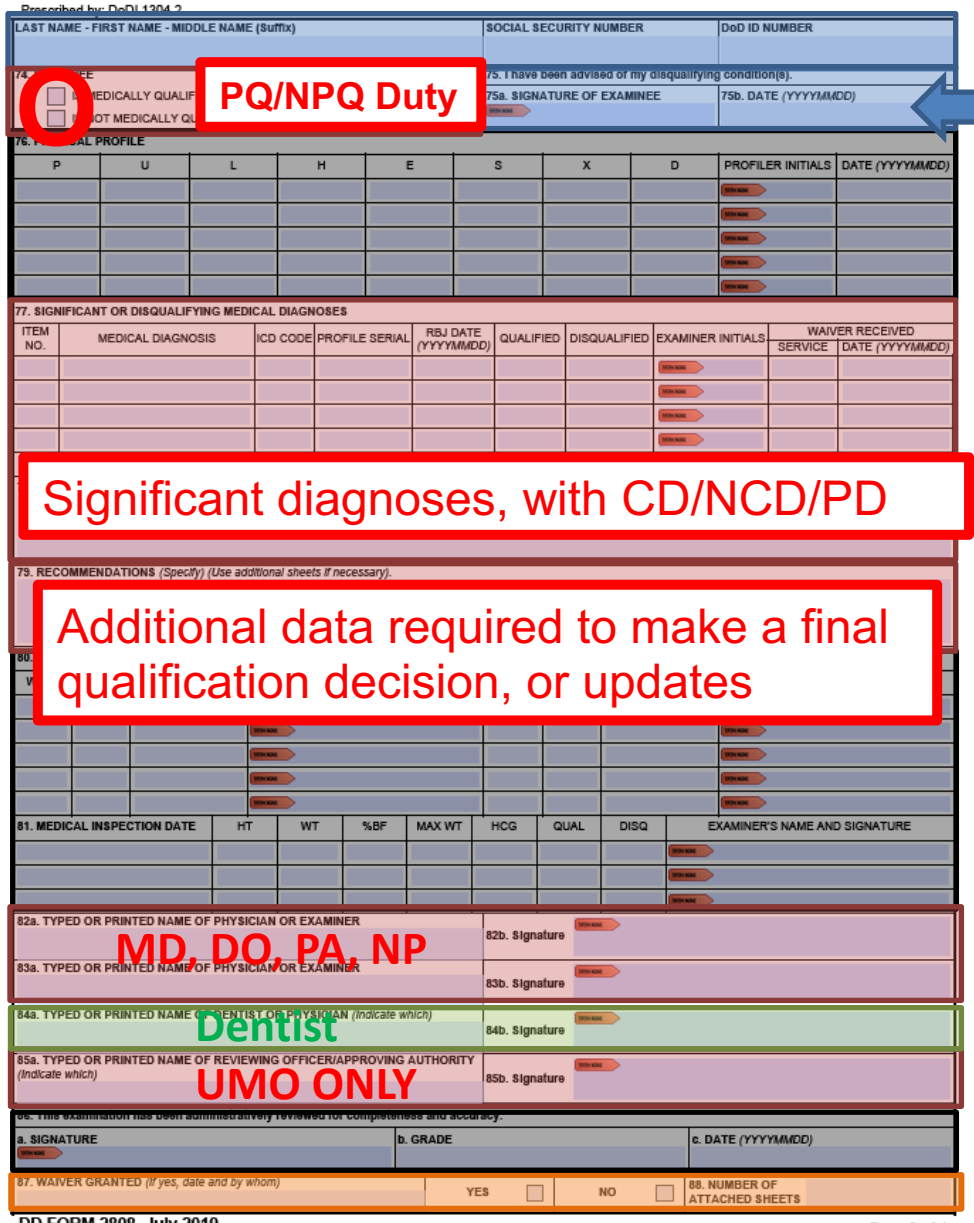



Patient signs ONLY if has disqualifying condition (NPQ)

***Anything CD results in NPQ status and will require a waiver***

DD FORM 2808, July 2019

Page 4 of 4




Significant diagnoses, with CD/NCD/PD

Additional data required to make a final qualification decision, or updates

Patient signs ONLY if has disqualifying condition (NPQ)

***Anything CD results in NPQ status and will require a waiver***

Once granted, add date waiver granted and authority (PERS)

DD FORM 2808, July 2019

Page 4 of 4

# A note about Waivers…

- Waivers of the standards do not make an applicant “physically qualified” but rather provide the applicant the opportunity to serve despite the fact that a disqualifying condition exists
  - All waived conditions should be reevaluated at every physical and as needed to determine if the condition has change, or is no longer stable

- Results of waivers (approved or denied) should be recorded on DD 2808, and placed on top of physical in patient’s chart

Prescribed by: DoDI 1304.2

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

74. EXAMINEE
- IS MEDICALLY QUALIFIED
- IS NOT MEDICALLY QUALIFIED

PQ Duty

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 | WAIVER RECEIVED DATE (YYYYMMDD) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Significant diagnoses, with NCD

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

PQ Duty

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

MD, DO, PA, NP

83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | 83b. Signature

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

Dentist

85a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY (Indicate which) | 85b. Signature

UMO ONLY

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

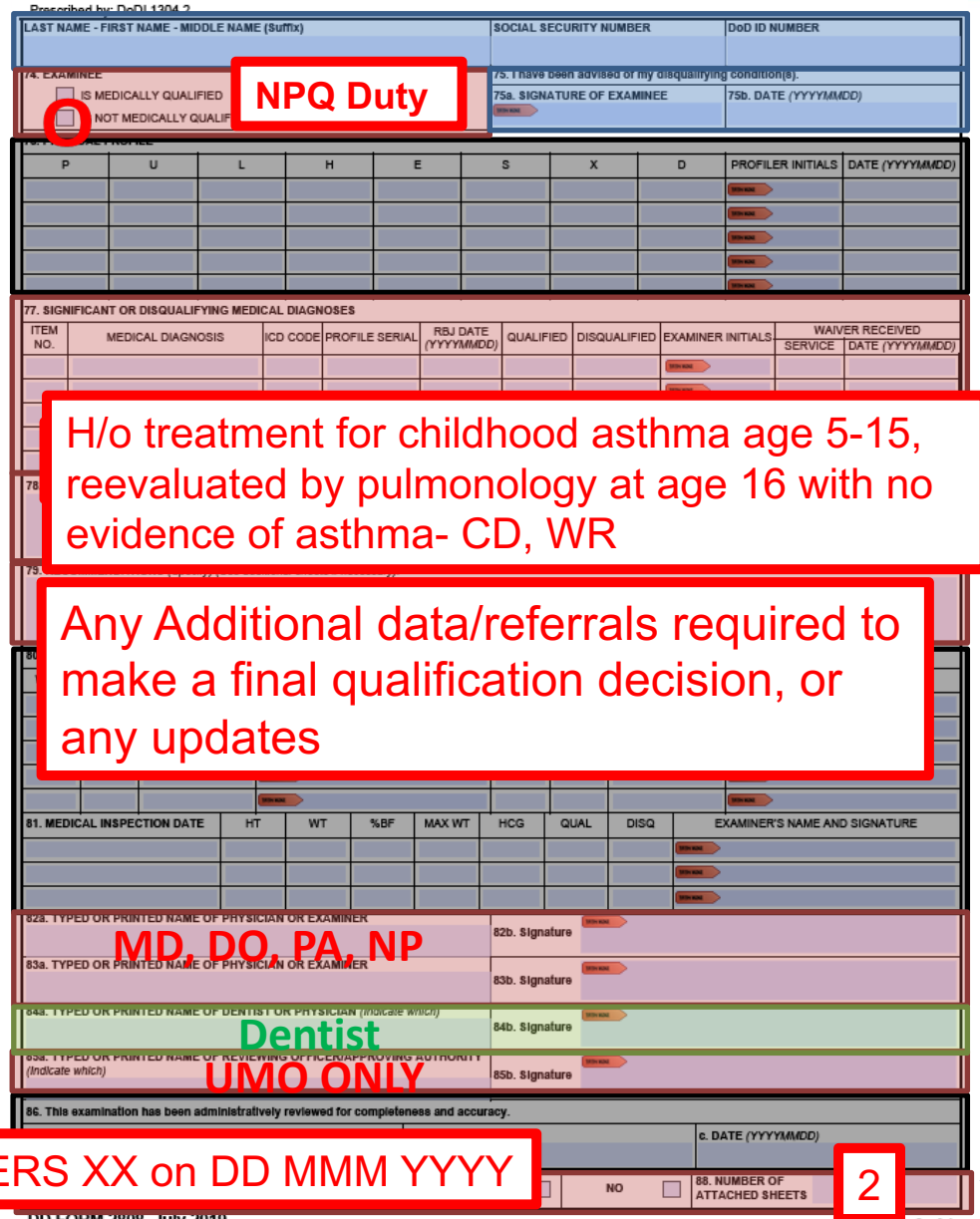
DD FORM 2808, July 2019 Page 3 of 4

Prescribed by: DoDI 1304.2

89. ADDITIONAL REMARKS

***If no disqualifying conditions found:***

DD FORM 2808, July 2019 Page 4 of 4




NPQ Duty

H/o treatment for childhood asthma age 5-15, reevaluated by pulmonology at age 16 with no evidence of asthma- CD, WR

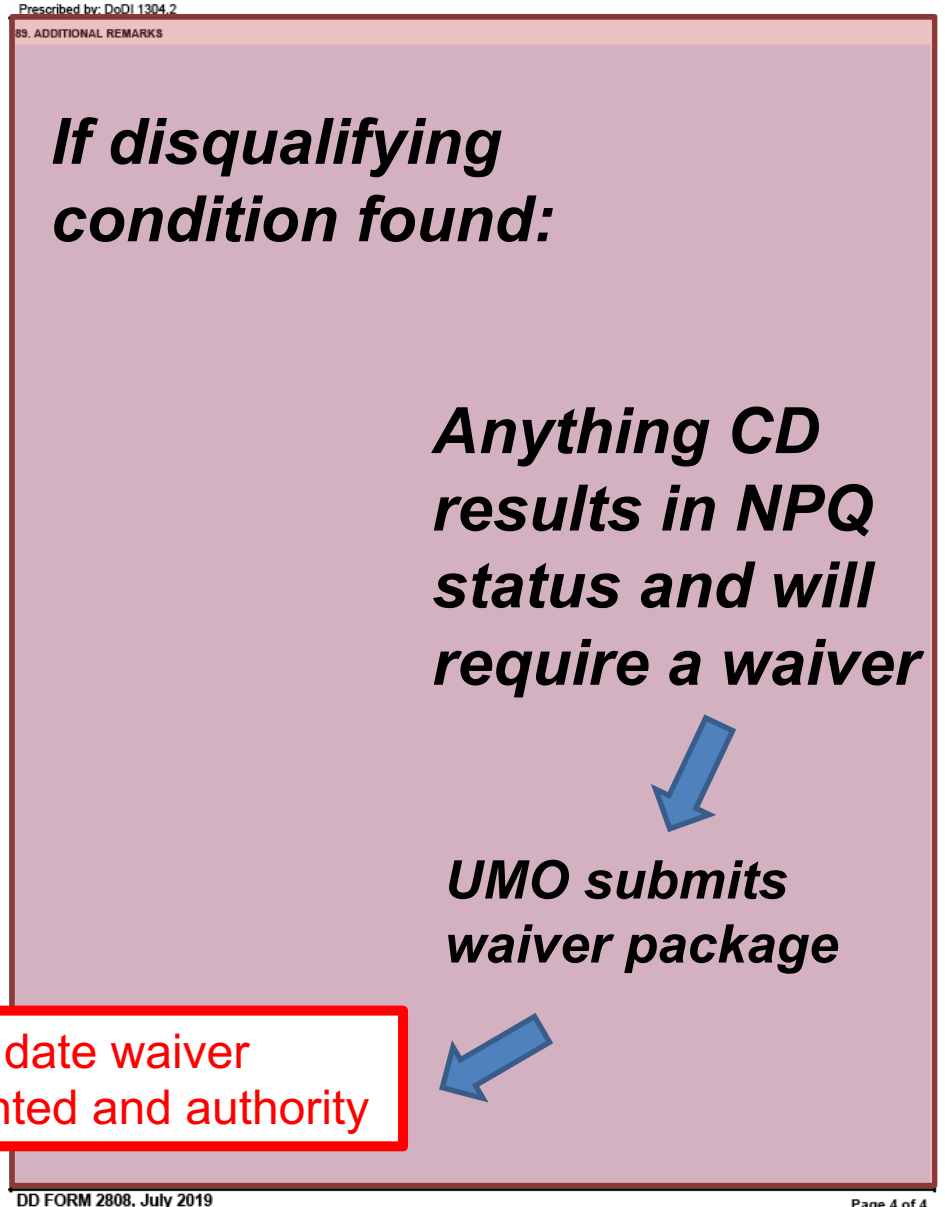
Any Additional data/referrals required to make a final qualification decision, or any updates

MD, DO, PA, NP

Dentist

UMO ONLY

H/o asthma- PERS XX on DD MMM YYYY



NAVMED-6150/2 (Rev. 4-70)
*(Formerly NAVMED 1346)*
S/N 0105-LF-209-5021

HEALTH RECORD

## SPECIAL DUTY MEDICAL ABSTRACT

**SUMMARY OF PHYSICAL EXAMINATIONS FOR SPECIAL DUTY**

| | DATE | PLACE | PURPOSE | RESULT - RECOMMENDATION (Defects Findings) | BUMED ACTION | SIG. OF M. O. |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |
| 7. | | | | | | |
| 8. | | | | | | |
| 9. | | | | | | |

PQ/NPQ Special Duty

**SUSPENSION FROM SPECIAL DUTY**

| | DATE *(From)* *(To)* | NO. OF DAYS | REASON FOR SUSPENSION | SIGNATURE OF MEDICAL OFFICER |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

**PERIODIC SPECIAL DUTY REQUALIFICATION**

| | DATE | SIG. OF M. O. | | DATE | SIG. OF M. O. | | DATE | SIG. OF M. O. |
|---|---|---|---|---|---|---|---|---|
| 1. | | | 7. | | | 13. | | |
| 2. | | | 8. | | | 14. | | |
| 3. | | | 9. | | | 15. | | |
| 4. | | | 10. | | | 16. | | |
| 5. | | | 11. | | | 17. | | |
| 6. | | | 12. | | | 18. | | |

| NAME *(Last)* *(First)* *(Middle)* | GRADE/RATE | SERVICE/SOC. SEC. NO. | ORGANIZATION | AGE |
|---|---|---|---|---|
| | | | | |

Patient's Information

**ALTITUDE TRAINING, AIR COMPRESSION AND OXYGEN TOLERANCE**

| | DATE | STATION | TYPE OF RUN-REACTION | SIG. OF M. O. |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

Pressure Test

**EXPLOSIVE DECOMPRESSION TRAINING**

| | DATE | STATION | ALTITUDES-REACTION | SIG. OF M. O. |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

**SUBMARINE ESCAPE AND DIVING TRAINING**

| | DATE | STATION | TYPE OF RUN-REACTION | SIG. OF M. O. |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

**VISUAL AND DISORIENTATION TRAINING**

| | DATE | STATION | TYPE OF TRAINING | SIG. OF M. O. |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

**CENTRIFUGE AND EJECTION SEAT TRAINING**

| | DATE | STATION | TYPE OF RUN-REACTIONS | SIG. OF M. O. |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

REMARKS:

**NAVMED-6150/2 (Rev. 4-70)**
*(Formerly NAVMED 1346)*
S/N 0105-LF-209-5021

| HEALTH RECORD | **SPECIAL DUTY MEDICAL ABSTRACT** |
|---|---|

**SUMMARY OF PHYSICAL EXAMINATIONS FOR SPECIAL DUTY**

| DATE | PLACE | PURPOSE | RESULT - RECOMMENDATION *(Defects-Waivers)* | BUMED ACTION | SIG. OF M. O. |
|---|---|---|---|---|---|
| 1. 31 JAN 19 | NUMI | Initial | PQ / ~~NPQ~~ Diving Duty | | |
| 2. | NSSC | Periodic | PQ / ~~NPQ~~ Submarine Duty | STAMP | / SIGN |
| 3. | | Candidate | PQ / NPQ Diving/SO Duty | | |
| 4. | | Designate | PQ / NPQ Submarine/NFD | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |

SUSPENSION FROM SPECIAL DUTY

# Additional Forms

- NAVPERS 1200/6 (Dec 2009), US Military Diving Medical Screening Questionnaire
- NAVMED 6420/2 (March 2019), Health and Reproductive Risk Counseling for Female Submariners and Submarine Candidates

Fillable

U. S. MILITARY DIVING MEDICAL SCREENING QUESTIONNAIRE

Supporting Directives MILPERSMAN 1220-100, 1220-200, 1220-300, and 1200-400

**PRIVACY ACT STATEMENT**

**AUTHORITY AND PURPOSE:** 5 U.S.C. 301, Departmental Regulations; and E.O. 9397 (SSN). Provided information is to assist officials and employees of the Navy in management, supervision and administration of Navy personnel (officer and enlisted) and the operations of related personnel affairs and functions.

**ROUTING USES:** Information will be utilized by Department of the Navy Officials in verifying qualifications for NSW/NSO programs.

| 1. NAME (Last, First, MI) | 2. RATE/RANK | 3. DOB |
|---|---|---|
| | | |

| 4. PRESENT COMMAND | 5. BRANCH OF SERVICE | 6. DATE |
|---|---|---|
| | | |

CONCEALMENT OF MEDICAL HISTORY WILL BE REPORTED TO HIGHER AUTHORITIES AND MAY RESULT IN PERMANENT DISQUALIFICATION.

DIVING MEDICAL QUESTIONS:

| | | |
|---|---|---|
| 1. Have you ever been found medically disqualified for a dive physical or any other physical at any time? | YES | NO |
| 2. Since your last physical, or in the last 18 months, have you been sick, injured, consulted a physician, used medication (including over-the-counter), or been hospitalized for any reason? | YES | NO |
| 3. Have you ever experienced any middle or inner ear dysfunction including inability to equalize middle ear pressure, inner or middle ear surgery, ringing, disequilibrium, hearing deficit? | YES | NO |
| 4. Is or has your uncorrected vision ever been worse than 20/20 in either eye? | YES | NO |
| 5. Do you have any difficulty distinguishing colors or seeing at night? | YES | NO |
| 6. Have you ever had any corneal surgery, or manipulation to correct poor vision? | YES | NO |
| 7. Since age 12, have you had asthma or wheezing at any time? | YES | NO |
| 8. Have you ever had a collapsed lung (pneumothorax), experienced pulmonary barotrauma, had a positive PPD, or taken INH in the past 6 months? | YES | NO |
| 9. Do you have any skin condition worsened by tight clothing, moisture, or sun exposure? | YES | NO |
| 10. Do you have any musculoskeletal condition that limits intense exercise, suffered any type of fracture in the last 3 months, or had any bone/joint surgery in the last 6 months? | YES | NO |
| 11. Have you ever been evaluated for, or treated for, any psychiatric problems (including depression, anxiety, personality disorder, etc.)?. | YES | NO |
| 12. Have you ever had legal, professional or personal problems due to alcohol use, or been diagnosed with dependence, or had any level of treatment for abuse? | YES | NO |
| 13. Have you ever had a migraine or other severe headache? | YES | NO |
| 14. Have you ever had seizures, convulsions or sustained a head injury resulting in loss of consciousness, loss of memory, concussion, or skull fracture? | YES | NO |
| 15. Have you ever had brain surgery? | YES | NO |
| 16. Do you have any area of altered sensation or strength in your body? | YES | NO |
| 17. Have you ever suffered Decompression Sickness or Arterial Gas Embolism? | YES | NO |
| 18. Do you suffer from motion sickness or fear of enclosed spaces? | YES | NO |

| 19. PATIENT SIGNATURE | 20. DATE |
|---|---|
| | |

NAVPERS 1200/6 (12-09) FOR OFFICIAL USE ONLY PRIVACY SENSITIVE Page 1 of 3

- NAVPERS 1200/6
  - Required within 30 days of arrival to NDSTC for initial OR advanced diving training
  - Last updated in Dec 2009
    - Has some inconsistencies with current version of MANMED 15-102

Unclassified

Fillable

U. S. MILITARY DIVING MEDICAL SCREENING QUESTIONNAIRE

Supporting Directives MILPERSMAN 1220-100, 1220-200, 1220-300, and 1200-400

**PRIVACY ACT STATEMENT**

**AUTHORITY AND PURPOSE:** 5 U.S.C. 301, Departmental Regulations; and E.O. 9397 (SSN). Provided information is to assist officials and employees of the Navy in management, supervision and administration of Navy personnel (officer and enlisted) and the operations of related personnel affairs and functions.

**ROUTING USES:** Information will be utilized by Department of the Navy Officials in verifying qualifications for NSW/NSO programs.

| 1. NAME (Last, First, MI) | 2. RATE/RANK | 3. DOB |
|---|---|---|
| | | |
| 4. PRESENT COMMAND | 5. BRANCH OF SERVICE | 6. DATE |
| | | |

CONCEALMENT OF MEDICAL HISTORY WILL BE REPORTED TO HIGHER AUTHORITIES AND MAY RESULT IN PERMANENT DISQUALIFICATION.

DIVING MEDICAL QUESTIONS:

| | | |
|---|---|---|
| 1. Have you ever been found medically disqualified for a dive physical or any other physical at any time? | YES | NO |
| 2. Since your last physical, or in the last 18 months, have you been sick, injured, consulted a physician, used medication (including over-the-counter), or been hospitalized for any reason? | YES | NO |
| 3. Have you ever experienced any middle or inner ear dysfunction including inability to equalize middle ear pressure, inner or middle ear surgery, ringing, disequilibrium, hearing deficit? | YES | NO |
| 4. Is or has your uncorrected vision ever been worse than 20/20 in either eye? | YES | NO |
| 5. Do you have any difficulty distinguishing colors or seeing at night? | YES | NO |
| 6. Have you ever had any corneal surgery, or manipulation to correct poor vision? | YES | NO |
| 7. Since age 12, have you had asthma or wheezing at any time? | YES | NO |
| 8. Have you ever had a collapsed lung (pneumothorax), experienced pulmonary barotrauma, had a positive PPD, or taken INH in the past 6 months? | YES | NO |
| 9. Do you have any skin condition worsened by tight clothing, moisture, or sun exposure? | YES | NO |
| 10. Do you have any musculoskeletal condition that limits intense exercise, suffered any type of fracture in the last 3 months, or had any bone/joint surgery in the last 6 months? | YES | NO |
| 11. Have you ever been evaluated for, or treated for, any psychiatric problems (including depression, anxiety, personality disorder, etc.)?. | YES | NO |
| 12. Have you ever had legal, professional or personal problems due to alcohol use, or been diagnosed with dependence, or had any level of treatment for abuse? | YES | NO |
| 13. Have you ever had a migraine or other severe headache? | YES | NO |
| 14. Have you ever had seizures, convulsions or sustained a head injury resulting in loss of consciousness, loss of memory, concussion, or skull fracture? | YES | NO |
| 15. Have you ever had brain surgery? | YES | NO |
| 16. Do you have any area of altered sensation or strength in your body? | YES | NO |
| 17. Have you ever suffered Decompression Sickness or Arterial Gas Embolism? | YES | NO |
| 18. Do you suffer from motion sickness or fear of enclosed spaces? | YES | NO |

| 19. PATIENT SIGNATURE | 20. DATE |
|---|---|
| | |

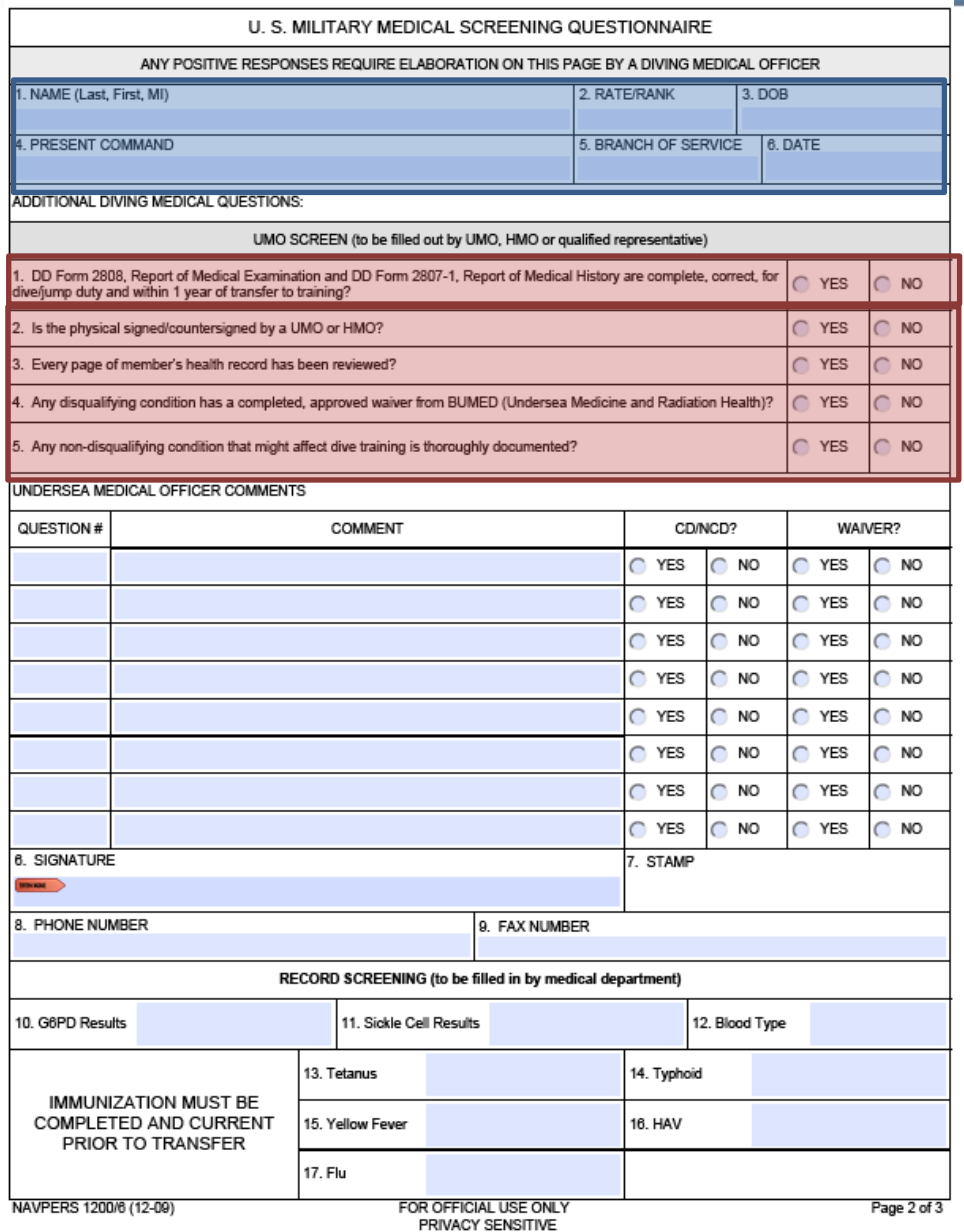
NAVPERS 1200/6 (12-00) FOR OFFICIAL USE ONLY Page 1 of 2

PRIVACY SENSITIVE

- NAVPERS 1200/6
  - Disqualification is determined by PERS
  - NPQ does not equal DQ

1. Have you ever been found medically disqualified for a dive physical or any other physical?
   - If NPQ with waiver – answer “NO”
   - If previous DQ from PERS – answer “YES”

Unclassified



U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

ANY POSITIVE RESPONSES REQUIRE ELABORATION ON THIS PAGE BY A DIVING MEDICAL OFFICER

| 1. NAME (Last, First, MI) | 2. RATE/RANK | 3. DOB |
|---|---|---|
| 4. PRESENT COMMAND | 5. BRANCH OF SERVICE | 6. DATE |

ADDITIONAL DIVING MEDICAL QUESTIONS:

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

| | | |
|---|---|---|
| 1. DD Form 2808, Report of Medical Examination and DD Form 2807-1, Report of Medical History are complete, correct, for dive/jump duty and within 1 year of transfer to training? | YES | NO |
| 2. Is the physical signed/countersigned by a UMO or HMO? | YES | NO |
| 3. Every page of member's health record has been reviewed? | YES | NO |
| 4. Any disqualifying condition has a completed, approved waiver from BUMED (Undersea Medicine and Radiation Health)? | YES | NO |
| 5. Any non-disqualifying condition that might affect dive training is thoroughly documented? | YES | NO |

UNDERSEA MEDICAL OFFICER COMMENTS

| QUESTION # | COMMENT | CD/NCD? | | WAIVER? | |
|---|---|---|---|---|---|
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |

6. SIGNATURE

7. STAMP

| 8. PHONE NUMBER | 9. FAX NUMBER |
|---|---|

RECORD SCREENING (to be filled in by medical department)

| 10. G6PD Results | 11. Sickle Cell Results | 12. Blood Type |
|---|---|---|

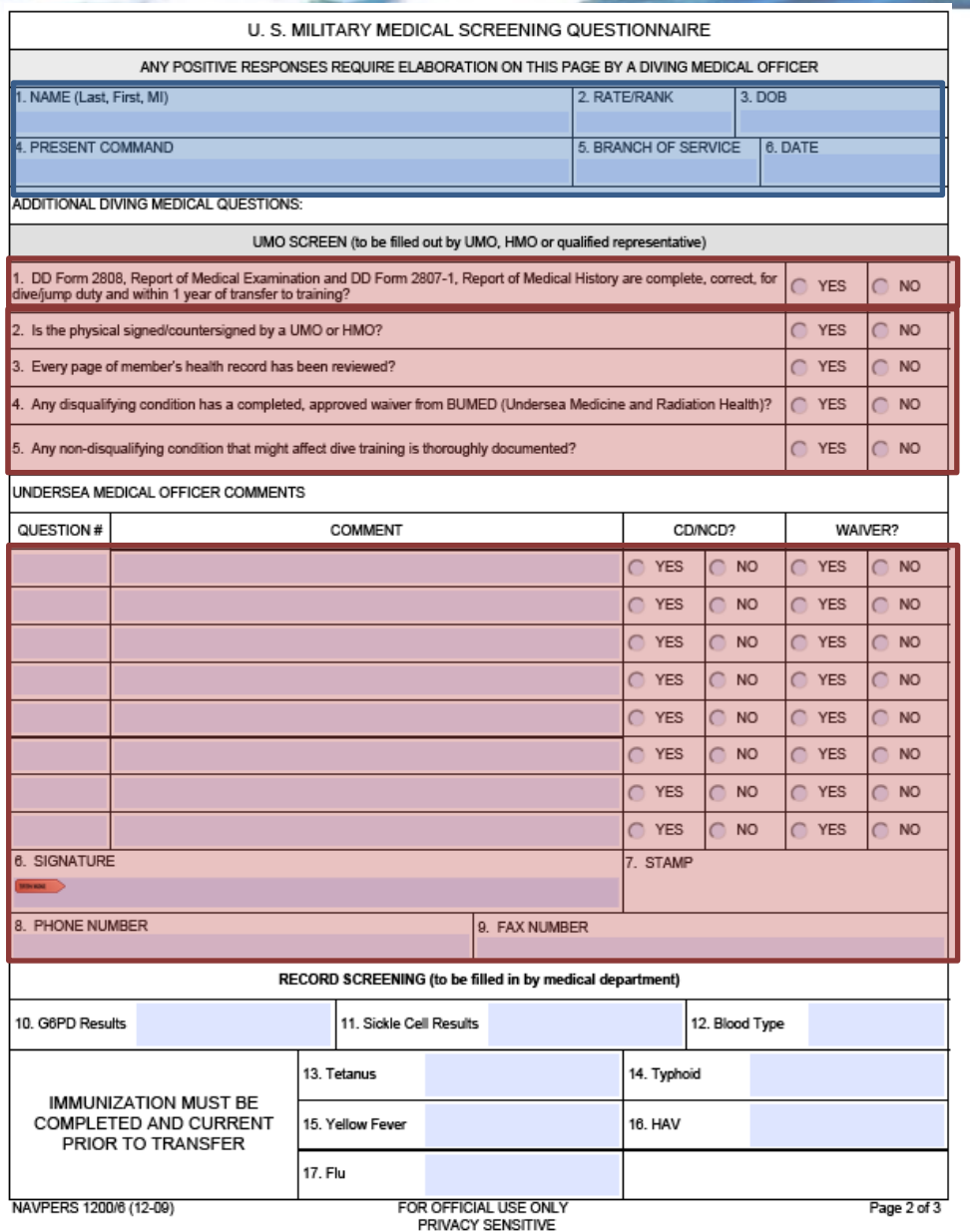
| IMMUNIZATION MUST BE COMPLETED AND CURRENT PRIOR TO TRANSFER | 13. Tetanus | 14. Typhoid |
|---|---|---|
| | 15. Yellow Fever | 16. HAV |
| | 17. Flu | |

NAVPERS 1200/6 (12-09) FOR OFFICIAL USE ONLY PRIVACY SENSITIVE Page 2 of 3

- NAVPERS 1200/6
  - Patient fills in demographics
  - UMO comments

1. DD Form 2808…within 1 year of transfer to training?

   - Current MANMED 15-102 allows physical to be completed within 2 years



U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

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| | | |
|---|---|---|
| 1. DD Form 2808, Report of Medical Examination and DD Form 2807-1, Report of Medical History are complete, correct, for dive/jump duty and within 1 year of transfer to training? | YES | NO |
| 2. Is the physical signed/countersigned by a UMO or HMO? | YES | NO |
| 3. Every page of member's health record has been reviewed? | YES | NO |
| 4. Any disqualifying condition has a completed, approved waiver from BUMED (Undersea Medicine and Radiation Health)? | YES | NO |
| 5. Any non-disqualifying condition that might affect dive training is thoroughly documented? | YES | NO |

UNDERSEA MEDICAL OFFICER COMMENTS

| QUESTION # | COMMENT | CD/NCD? | | WAIVER? | |
|---|---|---|---|---|---|
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |

| 6. SIGNATURE | 7. STAMP |
|---|---|
| 8. PHONE NUMBER | 9. FAX NUMBER |

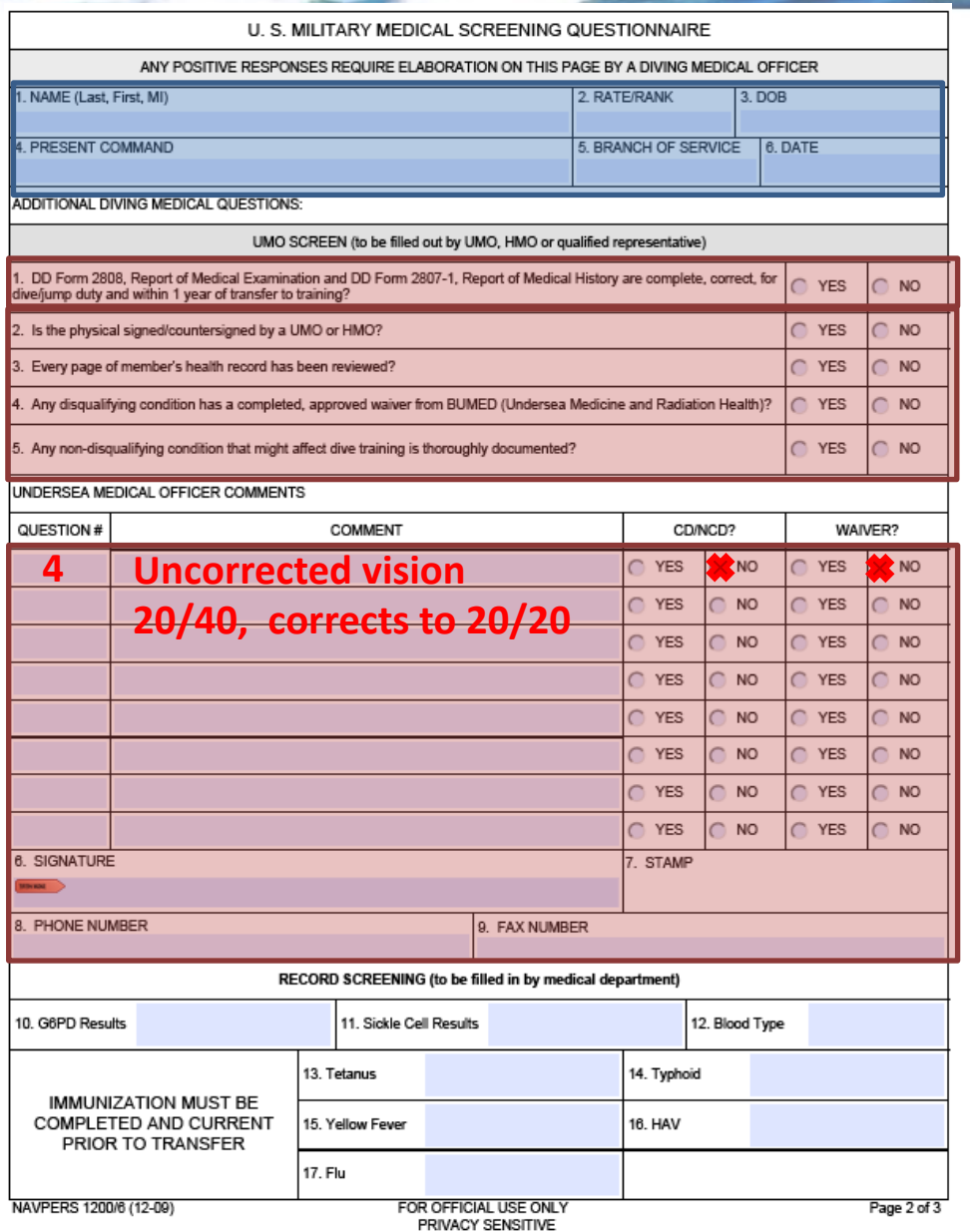
RECORD SCREENING (to be filled in by medical department)

| 10. G6PD Results | 11. Sickle Cell Results | 12. Blood Type |
|---|---|---|

| IMMUNIZATION MUST BE COMPLETED AND CURRENT PRIOR TO TRANSFER | | |
|---|---|---|
| | 13. Tetanus | 14. Typhoid |
| | 15. Yellow Fever | 16. HAV |
| | 17. Flu | |

NAVPERS 1200/6 (12-09) FOR OFFICIAL USE ONLY PRIVACY SENSITIVE Page 2 of 3

- NAVPERS 1200/6
  - UMO Comments from page 1
    - CD/NCD, Waiver?
    - No clear guidance, makes most sense
      - CD = "YES" Waiver = "YES"/"NO"
      - NCD = "NO" Waiver = "NO" or NA



U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

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|---|---|---|
| 4. PRESENT COMMAND | 5. BRANCH OF SERVICE | 6. DATE |

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UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

| | | |
|---|---|---|
| 1. DD Form 2808, Report of Medical Examination and DD Form 2807-1, Report of Medical History are complete, correct, for dive/jump duty and within 1 year of transfer to training? | YES | NO |
| 2. Is the physical signed/countersigned by a UMO or HMO? | YES | NO |
| 3. Every page of member's health record has been reviewed? | YES | NO |
| 4. Any disqualifying condition has a completed, approved waiver from BUMED (Undersea Medicine and Radiation Health)? | YES | NO |
| 5. Any non-disqualifying condition that might affect dive training is thoroughly documented? | YES | NO |

UNDERSEA MEDICAL OFFICER COMMENTS

| QUESTION # | COMMENT | CD/NCD? | WAIVER? |
|---|---|---|---|
| 4 | Uncorrected vision 20/40, corrects to 20/20 | YES ✖ NO | YES ✖ NO |
| | | YES NO | YES NO |
| | | YES NO | YES NO |
| | | YES NO | YES NO |
| | | YES NO | YES NO |
| | | YES NO | YES NO |
| | | YES NO | YES NO |
| | | YES NO | YES NO |

6. SIGNATURE — 7. STAMP

8. PHONE NUMBER — 9. FAX NUMBER

RECORD SCREENING (to be filled in by medical department)

| | | |
|---|---|---|
| 10. G6PD Results | 11. Sickle Cell Results | 12. Blood Type |

| | | |
|---|---|---|
| IMMUNIZATION MUST BE COMPLETED AND CURRENT PRIOR TO TRANSFER | 13. Tetanus | 14. Typhoid |
| | 15. Yellow Fever | 16. HAV |
| | 17. Flu | |

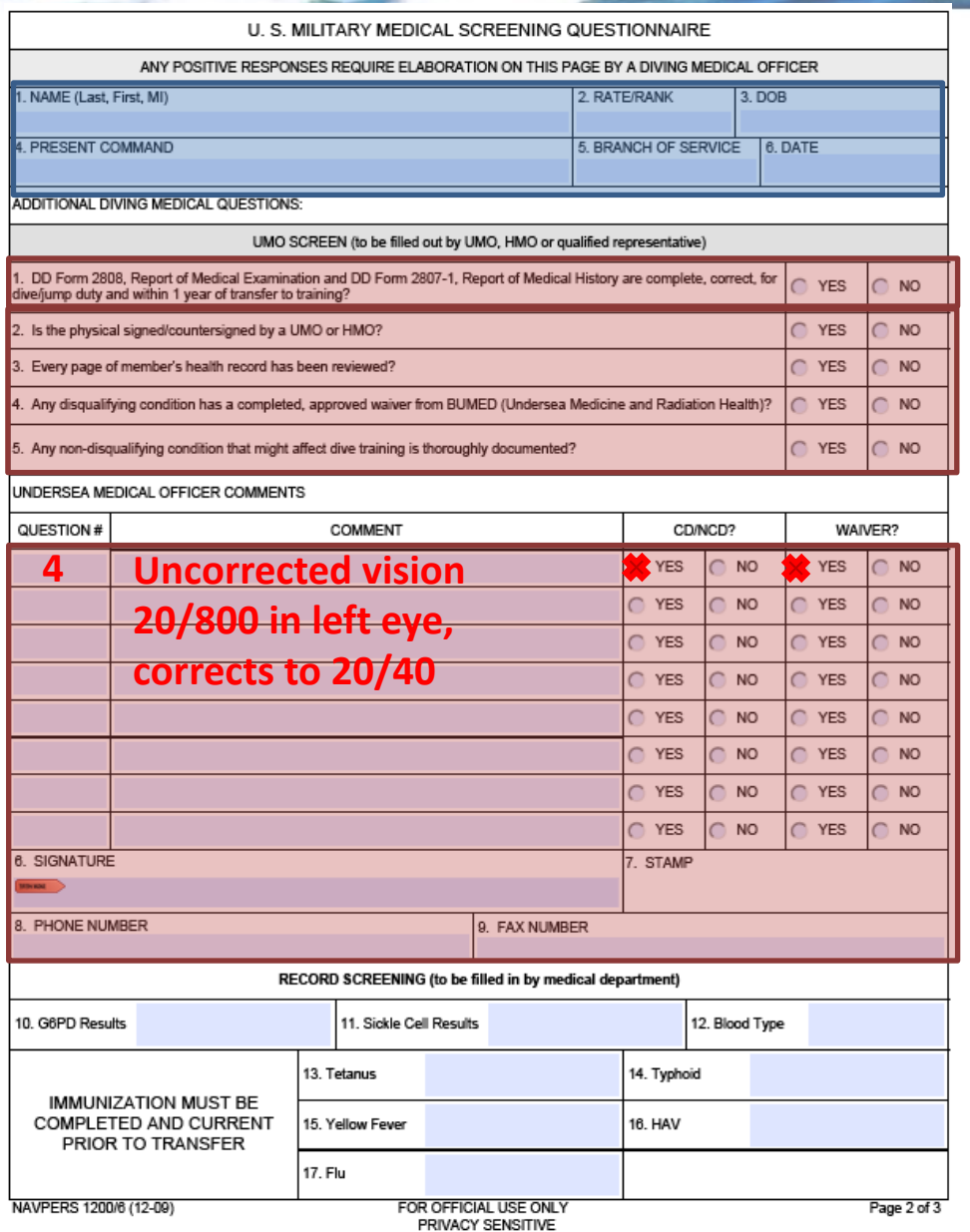
NAVPERS 1200/6 (12-09) FOR OFFICIAL USE ONLY PRIVACY SENSITIVE Page 2 of 3

- NAVPERS 1200/6
  - UMO Comments from page 1
    - Example:

4. Has your uncorrected vision ever been worse than 20/20 in either eye? "YES"

Uncorrected vision 20/40, corrects to 20/20, within standards

  - CD/NCD = "NO" Waiver? = "NO"



U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

ANY POSITIVE RESPONSES REQUIRE ELABORATION ON THIS PAGE BY A DIVING MEDICAL OFFICER

| 1. NAME (Last, First, MI) | 2. RATE/RANK | 3. DOB |
|---|---|---|
| 4. PRESENT COMMAND | 5. BRANCH OF SERVICE | 6. DATE |

ADDITIONAL DIVING MEDICAL QUESTIONS:

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

| | | |
|---|---|---|
| 1. DD Form 2808, Report of Medical Examination and DD Form 2807-1, Report of Medical History are complete, correct, for dive/jump duty and within 1 year of transfer to training? | YES | NO |
| 2. Is the physical signed/countersigned by a UMO or HMO? | YES | NO |
| 3. Every page of member's health record has been reviewed? | YES | NO |
| 4. Any disqualifying condition has a completed, approved waiver from BUMED (Undersea Medicine and Radiation Health)? | YES | NO |
| 5. Any non-disqualifying condition that might affect dive training is thoroughly documented? | YES | NO |

UNDERSEA MEDICAL OFFICER COMMENTS

| QUESTION # | COMMENT | CD/NCD? | | WAIVER? | |
|---|---|---|---|---|---|
| 4 | Uncorrected vision 20/800 in left eye, corrects to 20/40 | ✖ YES | NO | ✖ YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |

6. SIGNATURE

7. STAMP

8. PHONE NUMBER

9. FAX NUMBER

RECORD SCREENING (to be filled in by medical department)

| 10. G6PD Results | 11. Sickle Cell Results | 12. Blood Type |
|---|---|---|

| IMMUNIZATION MUST BE COMPLETED AND CURRENT PRIOR TO TRANSFER | 13. Tetanus | 14. Typhoid |
|---|---|---|
| | 15. Yellow Fever | 16. HAV |
| | 17. Flu | |

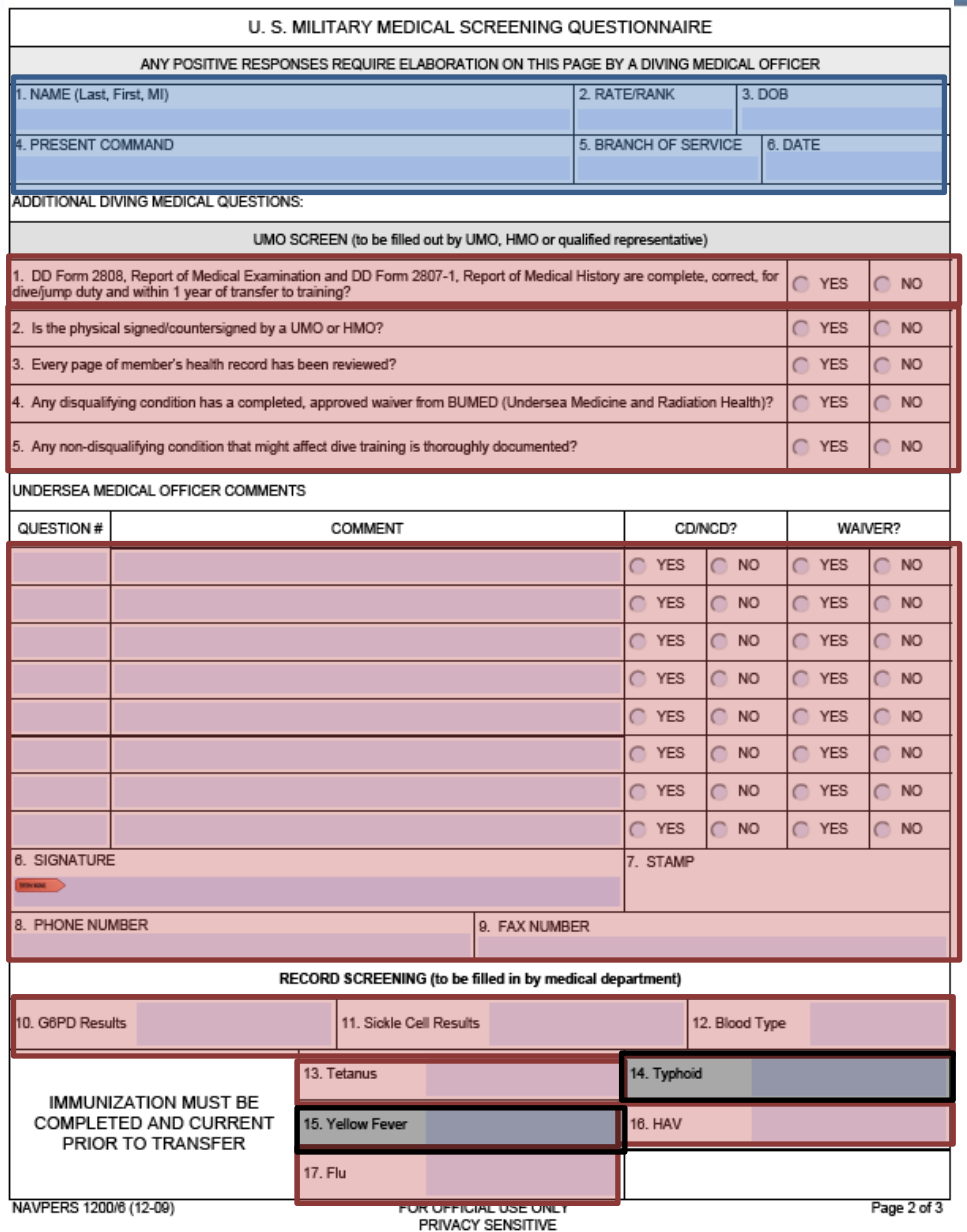
NAVPERS 1200/6 (12-09) FOR OFFICIAL USE ONLY PRIVACY SENSITIVE Page 2 of 3

- NAVPERS 1200/6
  - UMO Comments from page 1
    - Example:

4. Has your uncorrected vision ever been worse than 20/20 in either eye? "YES"

Uncorrected vision 20/800 in left eye, corrects to 20/40, waiver granted

  - CD/NCD = "YES" Waiver? = "YES"



U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

ANY POSITIVE RESPONSES REQUIRE ELABORATION ON THIS PAGE BY A DIVING MEDICAL OFFICER

| 1. NAME (Last, First, MI) | 2. RATE/RANK | 3. DOB |
|---|---|---|
| 4. PRESENT COMMAND | 5. BRANCH OF SERVICE | 6. DATE |

ADDITIONAL DIVING MEDICAL QUESTIONS:

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

| | | |
|---|---|---|
| 1. DD Form 2808, Report of Medical Examination and DD Form 2807-1, Report of Medical History are complete, correct, for dive/jump duty and within 1 year of transfer to training? | YES | NO |
| 2. Is the physical signed/countersigned by a UMO or HMO? | YES | NO |
| 3. Every page of member's health record has been reviewed? | YES | NO |
| 4. Any disqualifying condition has a completed, approved waiver from BUMED (Undersea Medicine and Radiation Health)? | YES | NO |
| 5. Any non-disqualifying condition that might affect dive training is thoroughly documented? | YES | NO |

UNDERSEA MEDICAL OFFICER COMMENTS

| QUESTION # | COMMENT | CD/NCD? | | WAIVER? | |
|---|---|---|---|---|---|
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |
| | | YES | NO | YES | NO |

| 6. SIGNATURE | 7. STAMP |
|---|---|
| 8. PHONE NUMBER | 9. FAX NUMBER |

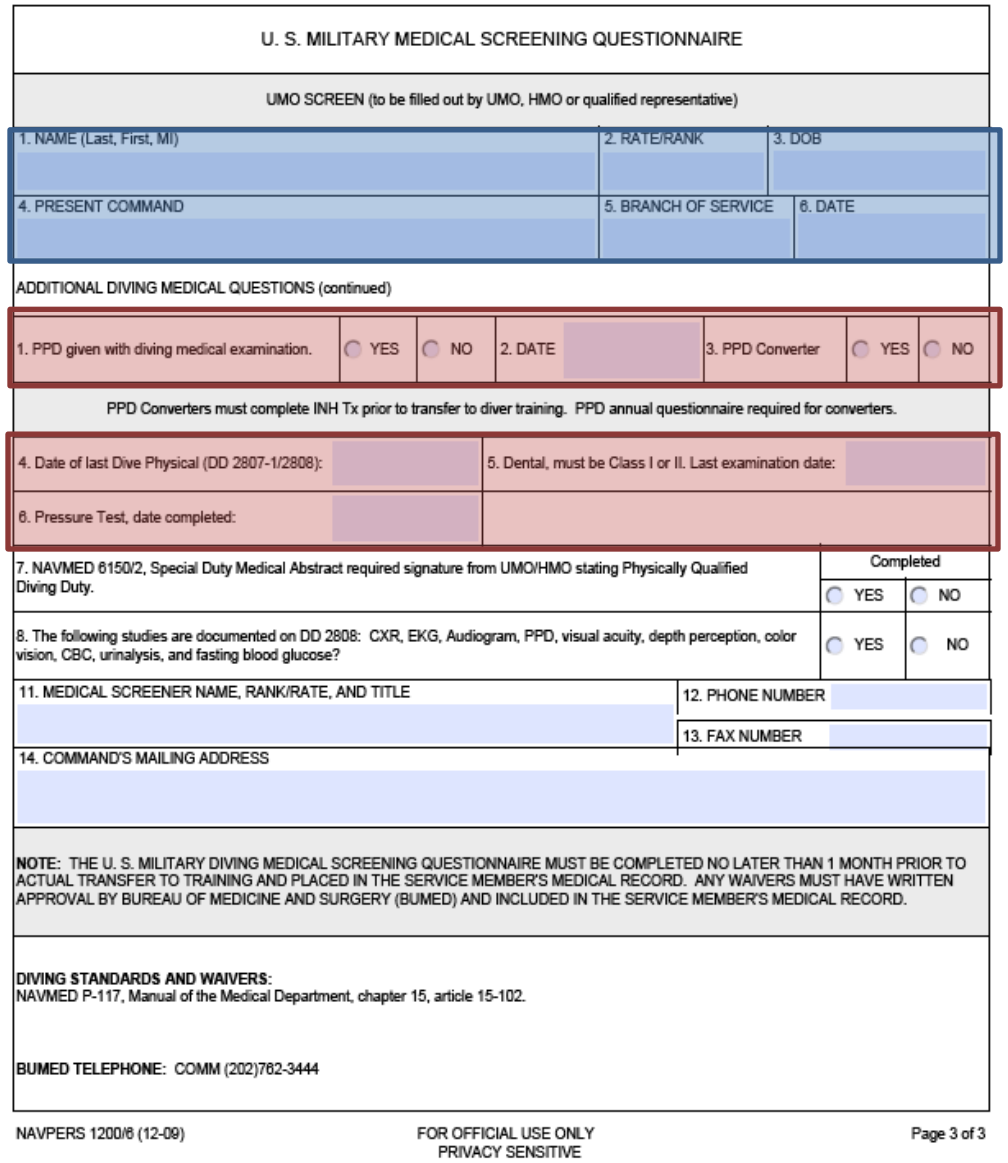
RECORD SCREENING (to be filled in by medical department)

| 10. G6PD Results | 11. Sickle Cell Results | 12. Blood Type |
|---|---|---|

| IMMUNIZATION MUST BE COMPLETED AND CURRENT PRIOR TO TRANSFER | 13. Tetanus | 14. Typhoid |
|---|---|---|
| | 15. Yellow Fever | 16. HAV |
| | 17. Flu | |

NAVPERS 1200/6 (12-09) FOR OFFICIAL USE ONLY PRIVACY SENSITIVE Page 2 of 3

- NAVPERS 1200/6
  - Record Screening
    - G6PD, Sickle Cell, Blood Type from DD2808
    - Tetanus, Flu, HAV from IMR or vaccine record
    - Yellow Fever, Typhoid vaccines are NOT REQUIRED



U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

| 1. NAME (Last, First, MI) | 2. RATE/RANK | 3. DOB |
|---|---|---|
| | | |
| 4. PRESENT COMMAND | 5. BRANCH OF SERVICE | 6. DATE |
| | | |

ADDITIONAL DIVING MEDICAL QUESTIONS (continued)

| 1. PPD given with diving medical examination. | YES | NO | 2. DATE | 3. PPD Converter | YES | NO |
|---|---|---|---|---|---|---|
| | | | | | | |

PPD Converters must complete INH Tx prior to transfer to diver training. PPD annual questionnaire required for converters.

| 4. Date of last Dive Physical (DD 2807-1/2808): | 5. Dental, must be Class I or II. Last examination date: |
|---|---|
| | |
| 6. Pressure Test, date completed: | |
| | |

| | Completed | |
|---|---|---|
| 7. NAVMED 6150/2, Special Duty Medical Abstract required signature from UMO/HMO stating Physically Qualified Diving Duty. | YES | NO |
| 8. The following studies are documented on DD 2808: CXR, EKG, Audiogram, PPD, visual acuity, depth perception, color vision, CBC, urinalysis, and fasting blood glucose? | YES | NO |

| 11. MEDICAL SCREENER NAME, RANK/RATE, AND TITLE | 12. PHONE NUMBER |
|---|---|
| | 13. FAX NUMBER |

14. COMMAND'S MAILING ADDRESS

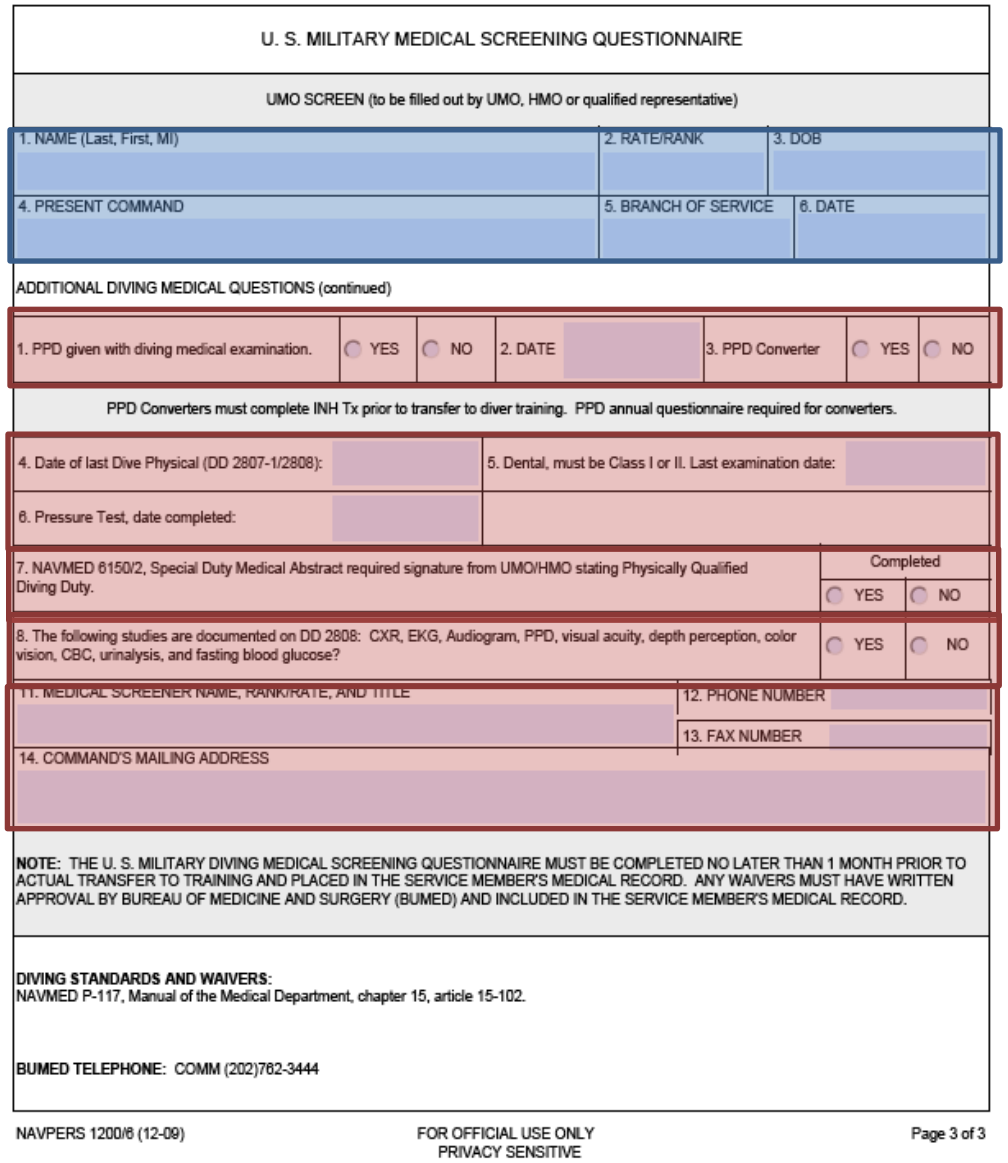
**NOTE:** THE U. S. MILITARY DIVING MEDICAL SCREENING QUESTIONNAIRE MUST BE COMPLETED NO LATER THAN 1 MONTH PRIOR TO ACTUAL TRANSFER TO TRAINING AND PLACED IN THE SERVICE MEMBER'S MEDICAL RECORD. ANY WAIVERS MUST HAVE WRITTEN APPROVAL BY BUREAU OF MEDICINE AND SURGERY (BUMED) AND INCLUDED IN THE SERVICE MEMBER'S MEDICAL RECORD.

**DIVING STANDARDS AND WAIVERS:**
NAVMED P-117, Manual of the Medical Department, chapter 15, article 15-102.

**BUMED TELEPHONE:** COMM (202)762-3444

NAVPERS 1200/6 (12-09) FOR OFFICIAL USE ONLY PRIVACY SENSITIVE Page 3 of 3

- NAVPERS 1200/6
  - Patient fills in demographics
  - Additional medical questions:
    - PPD and date
    - Date of last physical
    - Dental exam date (class I or II only)
    - Date of 60fsw pressure test



U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

| 1. NAME (Last, First, MI) | 2. RATE/RANK | 3. DOB |
|---|---|---|
| | | |
| 4. PRESENT COMMAND | 5. BRANCH OF SERVICE | 6. DATE |
| | | |

ADDITIONAL DIVING MEDICAL QUESTIONS (continued)

| 1. PPD given with diving medical examination. | YES | NO | 2. DATE | 3. PPD Converter | YES | NO |
|---|---|---|---|---|---|---|
| | | | | | | |

PPD Converters must complete INH Tx prior to transfer to diver training. PPD annual questionnaire required for converters.

| 4. Date of last Dive Physical (DD 2807-1/2808): | 5. Dental, must be Class I or II. Last examination date: |
|---|---|
| | |
| 6. Pressure Test, date completed: | |
| | |

| 7. NAVMED 6150/2, Special Duty Medical Abstract required signature from UMO/HMO stating Physically Qualified Diving Duty. | Completed YES | NO |
|---|---|---|
| | | |
| 8. The following studies are documented on DD 2808: CXR, EKG, Audiogram, PPD, visual acuity, depth perception, color vision, CBC, urinalysis, and fasting blood glucose? | YES | NO |
| | | |

| 11. MEDICAL SCREENER NAME, RANK/RATE, AND TITLE | 12. PHONE NUMBER |
|---|---|
| | 13. FAX NUMBER |
| 14. COMMAND'S MAILING ADDRESS | |
| | |

**NOTE:** THE U. S. MILITARY DIVING MEDICAL SCREENING QUESTIONNAIRE MUST BE COMPLETED NO LATER THAN 1 MONTH PRIOR TO ACTUAL TRANSFER TO TRAINING AND PLACED IN THE SERVICE MEMBER'S MEDICAL RECORD. ANY WAIVERS MUST HAVE WRITTEN APPROVAL BY BUREAU OF MEDICINE AND SURGERY (BUMED) AND INCLUDED IN THE SERVICE MEMBER'S MEDICAL RECORD.

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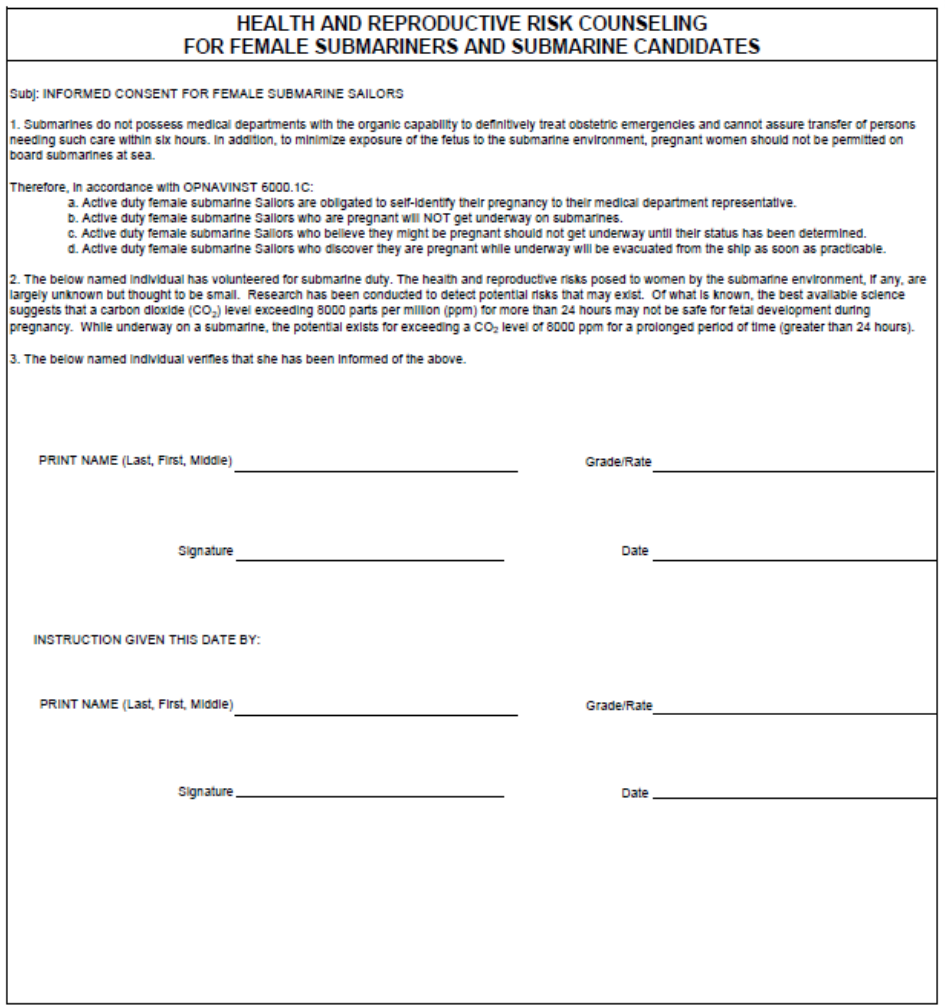
NAVPERS 1200/6 (12-09) FOR OFFICIAL USE ONLY PRIVACY SENSITIVE Page 3 of 3

- NAVPERS 1200/6
  - Additional medical questions:
    - Special duty abstract signed by UMO
    - DD2808 studies present:
      - CXR, EKG, Audiogram, PPD, visual acuity, color vision, CBC, urinalysis, fasting blood glucose
      - Depth perception?
    - Medical Screener Information



**HEALTH AND REPRODUCTIVE RISK COUNSELING FOR FEMALE SUBMARINERS AND SUBMARINE CANDIDATES**

Subj: INFORMED CONSENT FOR FEMALE SUBMARINE SAILORS

1. Submarines do not possess medical departments with the organic capability to definitively treat obstetric emergencies and cannot assure transfer of persons needing such care within six hours. In addition, to minimize exposure of the fetus to the submarine environment, pregnant women should not be permitted on board submarines at sea.

Therefore, in accordance with OPNAVINST 6000.1C:

a. Active duty female submarine Sailors are obligated to self-identify their pregnancy to their medical department representative.
b. Active duty female submarine Sailors who are pregnant will NOT get underway on submarines.
c. Active duty female submarine Sailors who believe they might be pregnant should not get underway until their status has been determined.
d. Active duty female submarine Sailors who discover they are pregnant while underway will be evacuated from the ship as soon as practicable.

2. The below named individual has volunteered for submarine duty. The health and reproductive risks posed to women by the submarine environment, if any, are largely unknown but thought to be small. Research has been conducted to detect potential risks that may exist. Of what is known, the best available science suggests that a carbon dioxide ($CO_2$) level exceeding 8000 parts per million (ppm) for more than 24 hours may not be safe for fetal development during pregnancy. While underway on a submarine, the potential exists for exceeding a $CO_2$ level of 8000 ppm for a prolonged period of time (greater than 24 hours).

3. The below named individual verifies that she has been informed of the above.

PRINT NAME (Last, First, Middle) _____ Grade/Rate _____

Signature _____ Date _____

INSTRUCTION GIVEN THIS DATE BY:

PRINT NAME (Last, First, Middle) _____ Grade/Rate _____

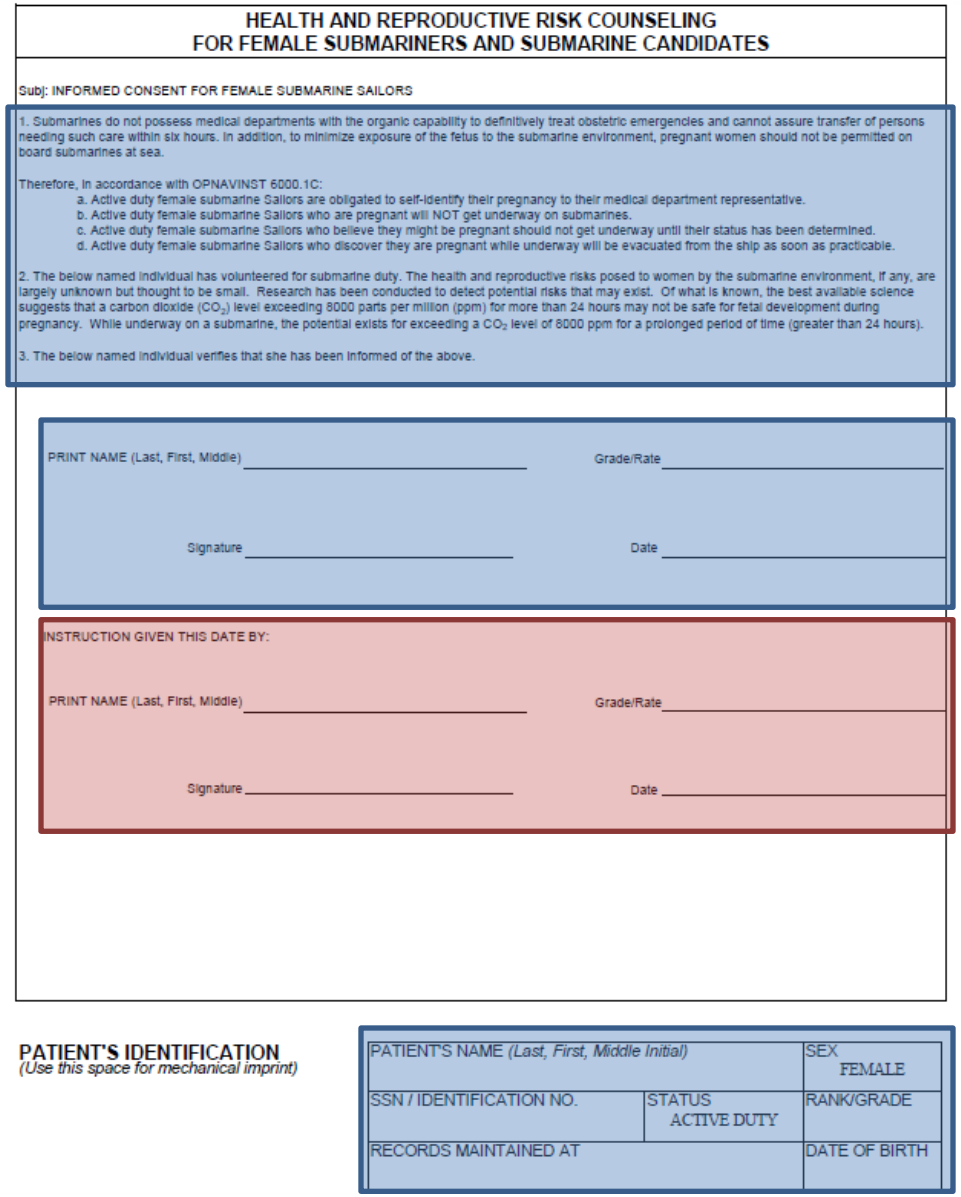
Signature _____ Date _____

**PATIENT'S IDENTIFICATION**
*(Use this space for mechanical imprint)*

| PATIENT'S NAME *(Last, First, Middle Initial)* | | SEX FEMALE |
|---|---|---|
| SSN / IDENTIFICATION NO. | STATUS ACTIVE DUTY | RANK/GRADE |
| RECORDS MAINTAINED AT | | DATE OF BIRTH |

NAVMED 6420/2 (03/2019)

- NAVMED 6420/2
  - Required for female submariners and submarine candidates at initial and periodic submarine duty physical exam
    - See MANMED 15-106
  - Last updated in March 2019
    - Old version does not include information listed in 1-3



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3. The below named individual verifies that she has been informed of the above.

PRINT NAME (Last, First, Middle) _____ Grade/Rate _____

Signature _____ Date _____

INSTRUCTION GIVEN THIS DATE BY:

PRINT NAME (Last, First, Middle) _____ Grade/Rate _____

Signature _____ Date _____

**PATIENT'S IDENTIFICATION**
*(Use this space for mechanical imprint)*

| PATIENT'S NAME *(Last, First, Middle Initial)* | | SEX FEMALE |
|---|---|---|
| SSN / IDENTIFICATION NO. | STATUS ACTIVE DUTY | RANK/GRADE |
| RECORDS MAINTAINED AT | | DATE OF BIRTH |

NAVMED 6420/2 (03/2019)

- NAVMED 6420/2
  - Patient should read information listed in 1-3 and sign below
  - UMO should be available to answer any questions, and sign that instruction was given

# Questions?